106TH CONGRESS
*2d Session*
HOUSE OF REPRESENTATIVES
REPORT
106–863

# DEPARTMENT OF VETERANS AFFAIRS HEALTH CARE PERSONNEL ACT OF 2000

SEPTEMBER 18, 2000.—Committed to the Committee of the Whole House on the State of the Union and ordered to be printed

Mr. STUMP, from the Committee on Veterans' Affairs, submitted the following

# R E P O R T

[To accompany H.R. 5109]

The Committee on Veterans' Affairs, to whom was referred the bill (H.R. 5109) to amend title 38, United States Code, to improve the personnel system of the Veterans Health Administration, and for other purposes, having considered the same, reports favorably thereon with an amendment and recommends that the bill as amended do pass.

The amendment is as follows:

Strike all after the enacting clause and insert the following:

**SECTION 1. SHORT TITLE; TABLE OF CONTENTS.**

(a) SHORT TITLE.—This Act may be cited as the "Department of Veterans Affairs Health Care Personnel Act of 2000".

(b) TABLE OF CONTENTS.—The table of contents of this Act is as follows:

**SEC. 2. REFERENCES TO TITLE 38, UNITED STATES CODE.**

Except as otherwise expressly provided, whenever in this Act an amendment or repeal is expressed in terms of an amendment to, or repeal of, a section or other provision, the reference shall be considered to be made to a section or other provision of title 38, United States Code.

# TITLE I—PERSONNEL MATTERS

**SEC. 101. ANNUAL NATIONAL PAY COMPARABILITY ADJUSTMENT FOR NURSES EMPLOYED BY DEPARTMENT OF VETERANS AFFAIRS.**

(a) REVISED PAY ADJUSTMENT PROCEDURES.—Section 7451 is amended—

(1) in subsection (d)—

(A) in paragraph (1)—

(i) by striking "The rates" and inserting "Subject to subsection (e), the rates"; and

(ii) in subparagraph (A), by inserting "and to be by the same percentage" after "to have the same effective date";

(B) in paragraph (2), by striking "Such" in the second sentence and inserting "Except as provided in paragraph (1)(A), such";

(C) in paragraph (3)(B)—

(i) by inserting after the first sentence the following new sentence: "To the extent practicable, the director shall use third-party industry wage surveys to meet the requirements of the preceding sentence.";

(ii) by inserting before the penultimate sentence the following new sentence: "To the extent practicable, all surveys conducted pursuant to this subparagraph or subparagraph (A) shall include the collection of salary midpoints, actual salaries, lowest and highest salaries, average salaries, bonuses, incentive pays, differential pays, actual beginning rates of pay and such other information needed to meet the purpose of this section."; and

(iii) in the penultimate sentence, by inserting "or published" after "completed";

(D) by striking clause (iii) of paragraph (3)(C);

(2) by striking subsection (e) and inserting the following:

"(e)(1) An adjustment in a rate of basic pay under subsection (d) may not reduce the rate of basic pay applicable to any grade of a covered position.

"(2) The director of a Department health-care facility, in determining whether to carry out a wage survey under subsection (d)(3) with respect to rates of basic pay for a grade of a covered position, may not consider as a factor in such determination the absence of a current recruitment or retention problem for personnel in that grade of that position. The director shall make such a determination based upon whether, in accordance with criteria established by the Secretary, there is a significant pay-related staffing problem at that facility in any grade for a position. If the director determines that there is such a problem, or that such a problem is likely to exist in the near future, the Director shall provide for a wage survey in accordance with paragraph (3) of subsection (d).

"(3) The Under Secretary for Health may, to the extent necessary to carry out the purposes of subsection (d), modify any determination made by the director of a Department health-care facility with respect to adjusting the rates of basic pay applicable to covered positions. Upon such action by the Under Secretary, any adjustment shall take effect on the first day of the first pay period beginning after such action. The Secretary shall ensure that the Under Secretary establishes a mechanism for the exercise of the authority in the preceding sentence.

"(4) Each director of a Department health-care facility shall provide to the Secretary, not later than July 31 each year, a report on staffing for covered positions at that facility. The report shall include the following:

"(A) Information on turnover rates and vacancy rates for each grade in a covered position, including a comparison of those rates with the rates for the preceding three years.

"(B) The director's findings concerning the review and evaluation of the facility's staffing situation, including whether there is, or is likely to be, in accordance with criteria established by the Secretary, a significant pay-related staffing problem at that facility for any grade of a covered position and, if so, whether a wage survey was conducted, or will be conducted with respect to that grade.

"(C) In any case in which the director conducts such a wage survey during the period covered by the report, information describing the survey and any actions taken or not taken based on the survey, and the reasons for taking (or not taking) such actions.

"(D) In any case in which the director, after finding that there is, or is likely to be, in accordance with criteria established by the Secretary, a significant pay-related staffing problem at that facility for any grade of a covered position, determines not to conduct a wage survey with respect to that position, a statement of the reasons why the director did not conduct such a survey.

"(5) Not later than September 30 of each year, the Secretary shall submit to the Committees on Veterans' Affairs of the Senate and House of Representatives a report on staffing for covered positions at Department healthcare facilities. Each such report shall include the following:

"(A) A summary and analysis of the information contained in the most recent reports submitted by facility directors under paragraph (4).

"(B) The information for each such facility specified in paragraph (4).";

(3) in subsection (f)—

(A) by striking "February 1 of 1991, 1992, and 1993" and inserting "March 1 of each year"; and

(B) by striking "subsection (d)(1)(A)" and inserting "subsection (d)"; and

(4) by striking subsection (g) and redesignating subsection (h) as subsection (g).

(b) REQUIRED CONSULTATIONS WITH NURSES.—(1) Subchapter II of chapter 73 is amended by adding at the end the following new section:

**"§ 7323. Required consultations with nurses**

"The Under Secretary for Health shall ensure that—

"(1) the director of a geographic service area, in formulating policy relating to the provision of patient care, shall consult regularly with a senior nurse executive or senior nurse executives; and

"(2) the director of a medical center shall, to the extent feasible, include a registered nurse as a member of any committee used at that medical center to provide recommendations or decisions on medical center operations or policy affecting clinical services, clinical outcomes, budget, or resources.".

(2) The table of sections at the beginning of such chapter is amended by inserting after the item relating to section 7322 the following new item:

"7323. Required consultations with nurses.".

**SEC. 102. SPECIAL PAY FOR DENTISTS.**

(a) FULL-TIME STATUS PAY.—Paragraph (1) of section 7435(b) is amended by striking "$3,500" and inserting "$9,000".

(b) SPECIAL PAY FOR POST-GRADUATE TRAINING.—Such section is amended by adding at the end the following new paragraph:

"(8) For a dentist who has successfully completed a post-graduate year of hospital-based training in a program accredited by the American Dental Association, an annual rate of $2,000 for each of the first two years of service after successful completion of that training.".

(c) TENURE PAY.—The table in paragraph (2)(A) of that section is amended to read as follows:

| "Length of Service | Rate | |
|---|---|---|
| | Minimum | Maximum |
| 1 year but less than 2 years | $1,000 | $2,000 |
| 2 years but less than 4 years | 4,000 | 5,000 |
| 4 years but less than 8 years | 5,000 | 8,000 |
| 8 years but less than 12 years | 8,000 | 12,000 |
| 12 years but less than 20 years | 12,000 | 15,000 |
| 20 years or more | 15,000 | 18,000.". |

(d) SCARCE SPECIALTY PAY.—Paragraph (3)(A) of that section is amended by striking "$20,000" and inserting "$30,000".

(e) GEOGRAPHIC PAY.—Paragraph (6) of that section is amended by striking "$5,000" and inserting "$12,000".

(f) RESPONSIBILITY PAY.—(1) The table in paragraph (4)(A) of that section is amended to read as follows:

| "Position | Rate | |
|---|---|---|
| | Minimum | Maximum |
| Chief of Staff or in an Executive Grade | $14,500 | $25,000 |
| Director Grade | 0 | 25,000 |
| Service Chief (or in a comparable position as determined by the Secretary) | 4,500 | 15,000.". |

(2) The table in paragraph (4)(B) of that section is amended to read as follows:

| "Position | Rate |
|---|---|
| Deputy Service Director | $20,000 |
| Service Director | 25,000 |
| Deputy Assistant Under Secretary for Health | 27,500 |
| Assistant Under Secretary for Health (or in a comparable position as determined by the Secretary) | 30,000.". |

(g) CREDITING OF INCREASED TENURE PAY FOR CIVIL SERVICE RETIREMENT.—Section 7438(b) is amended—

(1) by redesignating paragraph (5) as paragraph (6); and

(2) by inserting after paragraph (4) the following new paragraph:

"(5) Notwithstanding paragraphs (1) and (2), a dentist employed as a dentist in the Veterans Health Administration on the effective date of section 102 of the Department of Veterans Affairs Health Care Personnel Act of 2000 shall be entitled to have special pay paid to the dentist under section 7435(b)(2)(A) of this title (referred to as 'tenure pay') considered basic pay for the purposes of chapter 83 or 84, as appropriate, of title 5 only as follows:

"(A) In an amount equal to the amount that would have been so considered under such section on the day before such effective date based on the rates of special pay the dentist was entitled to receive under that section on the day before such effective date.

"(B) With respect to any amount of special pay received under that section in excess of the amount such dentist was entitled to receive under such section on the day before such effective date, in an amount equal to 25 percent of such excess amount for each two years that the physician or dentist has completed as a physician or dentist in the Veterans Health Administration after such effective date.".

(h) EFFECTIVE DATE.—The amendments made by this section shall apply with respect to agreements entered into by dentists under subchapter III of chapter 74 of title 38, United States Code, on or after the later of—

(1) the date of the enactment of this Act; and

(2) October 1, 2000.

(i) TRANSITION.—(1) In the case of an agreement entered into by a dentist under subchapter III of chapter 74 of title 38, United States Code, before the date of the enactment of this Act that expires after the effective date specified in subsection (h), the Secretary of Veterans Affairs and the dentist concerned may agree to terminate that agreement as of that effective date in order to permit a new agreement in accordance with section 7435 of such title, as amended by this section, to take effect as of that effective date.

(2) In the case of an agreement entered into under such subchapter before the date of the enactment of this Act that expires during the period beginning on the date of the enactment of this Act and ending on the effective date specified in subsection (h)(2), an extension or renewal of that agreement may not extend beyond that effective date.

(3) In the case of a dentist who begins employment with the Department of Veterans Affairs during the period beginning on the date of the enactment of this Act and ending on the effective date specified in subsection (h)(2) who is eligible for an agreement under subchapter III of chapter 74 of title 38, United States Code, any such agreement may not extend beyond that effective date.

**SEC. 103. EXEMPTION FOR PHARMACISTS FROM CEILING ON SPECIAL SALARY RATES.**

Section 7455(c)(1) is amended by inserting ", pharmacists," after "anesthetists".

**SEC. 104. PHYSICIAN ASSISTANT ADVISER TO UNDER SECRETARY FOR HEALTH.**

Section 7306(f) is amended—

(1) by striking "and" at the end of paragraph (1);

(2) by striking the period at the end of paragraph (2) and inserting "; and"; and

(3) by adding at the end the following new paragraph:

"(3) a physician assistant with appropriate experience (who may have a permanent duty station at a Department medical care facility in reasonable proximity to Washington, DC) advises the Under Secretary on all matters relating to the utilization and employment of physician assistants in the Administration.".

**SEC. 105. TEMPORARY FULL-TIME APPOINTMENTS OF CERTAIN MEDICAL PERSONNEL.**

(a) PHYSICIAN ASSISTANTS AWAITING CERTIFICATION OR LICENSURE.—Paragraph (2) of section 7405(c) is amended to read as follows:

"(2) A temporary full-time appointment may not be made for a period in excess of two years in the case of a person who—

"(A) has successfully completed—

"(i) a full course of nursing in a recognized school of nursing, approved by the Secretary; or

"(ii) a full course of training for any category of personnel described in paragraph (3) of section 7401 of this title, or as a physician assistant, in a recognized education or training institution approved by the Secretary; and

"(B) is pending registration or licensure in a State or certification by a national board recognized by the Secretary.".

(b) MEDICAL SUPPORT PERSONNEL.—That section is further amended—

(1) by redesignating paragraph (3) as paragraph (4); and

(2) by inserting after paragraph (2) the following new paragraph (3):

"(3)(A) Temporary full-time appointments of persons in positions referred to in subsection (a)(1)(D) shall not exceed three years.

"(B) Temporary full-time appointments under this paragraph may be renewed for one or more additional periods not in excess of three years each.".

**SEC. 106. QUALIFICATIONS OF SOCIAL WORKERS.**

Section 7402(b)(9) is amended by striking "a person must" and all that follows and inserting "a person must—

"(A) hold a master's degree in social work from a college or university approved by the Secretary; and

"(B) be licensed or certified to independently practice social work in a State, except that the Secretary may waive the requirement of licensure or certification for an individual social worker for a reasonable period of time recommended by the Under Secretary for Health.".

**SEC. 107. EXTENSION OF VOLUNTARY SEPARATION INCENTIVE PAYMENTS.**

The Department of Veterans Affairs Employment Reduction Assistance Act of 1999 (title XI of Public Law 106–117; 5 U.S.C. 5597 note) is amended as follows:

(1) Section 1102(c) is amended to read as follows:

"(c) LIMITATION.—The plan under subsection (a) shall be limited to 8,110 positions within the Department.".

(2) Section 1105(a) is amended by striking "26 percent" and inserting "15 percent".

(3) Section 1109(a) is amended by striking "December 31, 2000" and inserting "December 31, 2002".

# TITLE II—CONSTRUCTION AUTHORIZATION

**SEC. 201. AUTHORIZATION OF MAJOR MEDICAL FACILITY PROJECTS.**

(a) FISCAL YEAR 2001 PROJECTS.—The Secretary of Veterans Affairs may carry out the following major medical facility projects, with each project to be carried out in the amount specified for that project:

(1) Construction of a psychogeriatric care building at the Department of Veterans Affairs Medical Center, Palo Alto, California, in an amount not to exceed $26,600,000.

(2) Construction of a utility plant and electrical vault at the Department of Veterans Affairs Medical Center, Miami, Florida, in an amount not to exceed $23,600,000.

(3) Seismic corrections, clinical consolidation, and other improvements at the Department of Veterans Affairs Medical Center, Long Beach, California, in an amount not to exceed $51,700,000.

(b) ADDITIONAL FISCAL YEAR 2000 PROJECT.—The Secretary is authorized to carry out a project for the renovation of psychiatric nursing units at the Department of Veterans Affairs Medical Center, Murfreesboro, Tennessee, in an amount not to exceed $14,000,000.

**SEC. 202. AUTHORIZATION OF APPROPRIATIONS.**

(a) IN GENERAL.—There are authorized to be appropriated to the Secretary of Veterans Affairs for fiscal years 2001 and 2002 for the Construction, Major Projects, account, $101,900,000 for the projects authorized in section 101(a).

(b) LIMITATION.—The projects authorized in section 101(a) may only be carried out using—

(1) funds appropriated for fiscal year 2001 or 2002 pursuant to the authorization of appropriations in subsection (a);

(2) funds appropriated for Construction, Major Projects for a fiscal year before fiscal year 2001 that remain available for obligation; and

(3) funds appropriated for Construction, Major Projects for fiscal year 2001 or 2002 for a category of activity not specific to a project.

# TITLE III—MILITARY SERVICE ISSUES

**SEC. 301. MILITARY SERVICE HISTORY.**

(a) MILITARY HISTORIES.—The Secretary of Veterans Affairs, in carrying out the responsibilities of the Secretary under chapter 17 of title 38, United States Code, shall ensure that—

(1) during at least one clinical evaluation of a patient in a facility of the Department, a protocol is used to identify pertinent military experiences and exposures of the patient that may contribute to the health status of the patient; and

(2) pertinent information relating to the military history of the patient is included in the Department's medical records of the patient.

(b) REPORT.—Not later than nine months after the date of the enactment of this Act, the Secretary shall submit to the Committees on Veterans' Affairs of the Senate and House of Representatives a report on the feasibility and desirability of using a computer-based system in conducting clinical evaluations referred to in subsection (a)(1).

**SEC. 302. STUDY OF POST-TRAUMATIC STRESS DISORDER IN VIETNAM VETERANS.**

(a) STUDY ON POST-TRAUMATIC STRESS DISORDER.—Not later than 10 months after the date of the enactment of this Act, the Secretary of Veterans Affairs shall enter into a contract with an appropriate entity to carry out a study on post-traumatic stress disorder.

(b) FOLLOW-UP STUDY.—The contract under subsection (a) shall provide for a follow-up study to the study conducted in accordance with section 102 of the Veterans Health Care Amendments of 1983 (Public Law 98–160). Such follow-up study shall use the data base and sample of the previous study.

(c) INFORMATION TO BE INCLUDED.—The study conducted pursuant to this section shall be designed to yield information on—

(1) the long-term course of post-traumatic stress disorder;

(2) any long-term medical consequences of post-traumatic stress disorder;

(3) whether particular subgroups of veterans are at greater risk of chronic or more severe problems with such disorder; and

(4) the services used by veterans who have post-traumatic stress disorder and the effect of those services on the course of the disorder.

(d) REPORT.—The Secretary shall submit to the Committees of Veterans' Affairs of the Senate and House of Representatives a report on the results of the study under this section. The report shall be submitted no later than October 1, 2004.

# TITLE IV—MEDICAL ADMINISTRATION

**SEC. 401. PILOT PROGRAM FOR COORDINATION OF HOSPITAL BENEFITS.**

(a) IN GENERAL.—Chapter 17 is amended by inserting after section 1725 the following new section:

**"§ 1725A. Coordination of hospital benefits: pilot program**

"(a) The Secretary may carry out a pilot program in not more than four geographic areas of the United States to improve access to, and coordination of, inpatient care of eligible veterans. Under the pilot program, the Secretary, subject to subsection (b), may pay certain costs described in subsection (b) for which an eligible

veteran would otherwise be personally liable. The authority to carry out the pilot program shall expire on September 30, 2005.

"(b) In carrying out the program described in subsection (a), the Secretary may pay the costs authorized under this section for hospital care and medical services furnished on an inpatient basis in a non-Department hospital to an eligible veteran participating in the program. Such payment may cover the costs for applicable plan deductibles and coinsurance and the reasonable costs of such inpatient care and medical services not covered by any applicable health-care plan of the veteran, but only to the extent such care and services are of the kind authorized under this chapter. The Secretary shall limit the care and services for which payment may be made under the program to general medical and surgical services and shall require that such services may be provided only upon preauthorization by the Secretary.

"(c)(1) A veteran described in paragraph (1) or (2) of section 1710(a) of this title is eligible to participate in the pilot program if the veteran—

"(A) is enrolled to receive medical services from an outpatient clinic operated by the Secretary which is (i) within reasonable proximity to the principal residence of the veteran, and (ii) located within the geographic area in which the Secretary is carrying out the program described in subsection (a);

"(B) has received care under this chapter within the 24-month period preceding the veteran's application for enrollment in the pilot program;

"(C) as determined by the Secretary before the hospitalization of the veteran (i) requires such hospital care and services for a non-service-connected condition, and (ii) could not receive such services from a clinic operated by the Secretary; and

"(D) elects to receive such care under a health-care plan (other than under this title) under which the veteran is entitled to receive such care.

"(2) Nothing in this section shall be construed to reduce the authority of the Secretary to contract with non-Department facilities for care of a service-connected disability of a veteran.

"(3) Notwithstanding subparagraph (D) of paragraph (1), the Secretary shall ensure that not less than 15 percent of the veterans participating in the program are veterans who do not have a health-care plan.

"(d) As part of the program under this section, the Secretary shall, through provision of case-management, coordinate the care being furnished directly by the Secretary and care furnished under the program in non-Department hospitals to veterans participating in the program.

"(e)(1) In designating geographic areas in which to establish the program under subsection (a), the Secretary shall ensure that—

"(A) the areas designated are geographically dispersed;

"(B) at least 70 percent of the veterans who reside in a designated area reside at least two hours driving distance from the closest medical center operated by the Secretary which provides medical and surgical hospital care; and

"(C) the establishment of the program in any such area would not result in jeopardizing the critical mass of patients needed to maintain a Department medical center that serves that area.

"(2) Notwithstanding paragraph (1)(B), the Secretary may designate for participation in the program at least one area which is in proximity to a Department medical center which, as a result of a change in mission of that center, does not provide hospital care.

"(f)(1) Not later than September 30, 2002, the Secretary shall submit to the Committees on Veterans' Affairs of the Senate and House of Representatives a report on the experience in implementing the pilot program under subsection (a).

"(2) Not later than September 30, 2004, the Secretary shall submit to those committees a report on the experience in operating the pilot program during the first two full fiscal years during which the pilot program is conducted. That report shall include—

"(A) a comparison of the costs incurred by the Secretary under the program and the cost experience for the calendar year preceding establishment of the program at each site at which the program is operated;

"(B) an assessment of the satisfaction of the participants in the program; and

"(C) an analysis of the effect of the program on access and quality of care for veterans.

"(g) The total amount expended for the pilot program in any fiscal year (including amounts for administrative costs) may not exceed $50,000,000.

"(h) For purposes of this section, the term 'health-care plan' has the meaning given that term in section 1725(f)(3) of this title.".

(b) CLERICAL AMENDMENT.—The table of sections at the beginning of such chapter is amended by inserting after the item relating to section 1725 the following new item:

"1725A. Coordination of hospital benefits: pilot program.".

**SEC. 402. BENEFITS FOR PERSONS DISABLED BY PARTICIPATION IN COMPENSATED WORK THERAPY PROGRAM.**

Section 1151(a)(2) is amended—

(1) by inserting "(A)" after "proximately caused"; and

(2) by inserting before the period at the end the following: ", or (B) by participation in a program (known as a 'compensated work therapy program') under section 1718 of this title".

**SEC. 403. EXTENSION OF AUTHORITY TO ESTABLISH RESEARCH AND EDUCATION CORPORATIONS.**

Section 7368 is amended by striking "December 31, 2000" and inserting "December 31, 2005".

**SEC. 404. DEPARTMENT OF VETERANS AFFAIRS FISHER HOUSES.**

(a) AUTHORITY.—Subchapter I of chapter 17 of title 38, United States Code, is amended by adding at the end the following new section:

**"§ 1708. Temporary lodging**

"(a) The Secretary may furnish persons described in subsection (b) with temporary lodging in a Fisher house or other appropriate facility in connection with the examination, treatment, or care of a veteran under this chapter or, as provided for under subsection (e)(5), in connection with benefits administered under this title.

"(b) Persons to whom the Secretary may provide lodging under subsection (a) are the following:

"(1) A veteran who must travel a significant distance to receive care or services under this title.

"(2) A member of the family of a veteran and others who accompany a veteran and provide the equivalent of familial support for such veteran.

"(c) In this section, the term 'Fisher house' means a housing facility that—

"(1) is located at, or in proximity to, a Department medical facility;

"(2) is available for residential use on a temporary basis by patients of that facility and others described in subsection (b)(2); and

"(3) is constructed by, and donated to the Secretary by, the Zachary and Elizabeth M. Fisher Armed Services Foundation.

"(d) The Secretary may establish charges for providing lodging under this section. The proceeds from such charges shall be credited to the medical care account and shall be available until expended for the purposes of providing such lodging.

"(e) The Secretary shall prescribe regulations to carry out this section. Such regulations shall include provisions—

"(1) limiting the duration of such lodging;

"(2) establishing standards and criteria under which medical facilities may set charges for such lodging;

"(3) establishing criteria for persons considered to be accompanying a veteran;

"(4) establishing criteria for the use of such premises; and

"(5) any other limitations, conditions, and priorities that the Secretary considers appropriate with respect to temporary lodging under this section.".

(b) CLERICAL AMENDMENT.—The table of sections at the beginning of such chapter is amended by inserting after the item relating to section 1707 the following new item:

"1708. Temporary lodging.".

**SEC. 405. EXTENSION OF ANNUAL REPORT OF COMMITTEE ON MENTALLY ILL VETERANS.**

Section 7321(d)(2) is amended by striking "three" and inserting "six".

**SEC. 406. EXCEPTION TO RECAPTURE RULE.**

Section 8136 is amended—

(1) by inserting "(a)" at the beginning of the text of the section; and

(2) by adding at the end the following new subsection:

"(b) The establishment and operation by the Secretary of an outpatient clinic in facilities described in subsection (a) shall not constitute grounds entitling the United States to any recovery under that subsection.".

**SEC. 407. CHANGE TO ENHANCED USE LEASE CONGRESSIONAL NOTIFICATION PERIOD.**

Paragraph (2) of section 8163(c) is amended to read as follows:

"(2) The Secretary may not enter into an enhanced use lease until the end of the 90-day period beginning on the date of the submission of notice under paragraph (1).".

**SEC. 408. TECHNICAL AND CONFORMING CHANGES.**

(a) REQUIREMENT TO PROVIDE CARE.—Section 1710A(a) is amended by inserting "(subject to section 1710(a)(4) of this title)" after "Secretary" the first place it appears.

(b) CONFORMING AMENDMENT.—Section 1710(a)(4) is amended by striking "requirement in" and inserting "requirements in section 1710A(a) and".

**SEC. 409. RELEASE OF REVERSIONARY INTEREST OF THE UNITED STATES IN CERTAIN REAL PROPERTY PREVIOUSLY CONVEYED TO THE STATE OF TENNESSEE.**

(a) RELEASE OF INTEREST.—The Secretary of Veterans Affairs shall execute such legal instruments as necessary to release the reversionary interest of the United States described in subsection (b) in a certain parcel of real property conveyed to the State of Tennessee pursuant to the Act entitled "An Act authorizing the transfer of certain property of the Veterans' Administration (in Johnson City, Tennessee) to the State of Tennessee", approved June 6, 1953 (67 Stat. 54).

(b) SPECIFIED REVERSIONARY INTEREST.—Subsection (a) applies to the reversionary interest of the United States required under section 2 of the Act referred to in subsection (a), requiring use of the property conveyed pursuant to that Act to be primarily for training of the National Guard and for other military purposes.

(c) CONFORMING AMENDMENT.—Section 2 of such Act is repealed.

## INTRODUCTION

H.R. 5109 addresses a range of issues reviewed by the Committee in hearings, meetings, and through other oversight mechanisms over the course of this year.

On February 17, 2000, the Committee on Veterans' Affairs held a hearing to receive information on the VA Medical Care budget request for FY 2001. Those testifying at the hearing included: the Honorable Togo D. West, Jr., Secretary of Veterans Affairs; representatives of the Independent Budget, Mr. Gordon H. Mansfield, Executive Director, Paralyzed Veterans of America; Mr. David Gorman, Executive Director, Disabled American Veterans; Mr. David E. Woodbury, National Executive Director, AMVETS; Mr. Dennis M. Cullinan, National Legislative Director, Veterans of Foreign Wars; Mr. Philip Wilkerson, Deputy Director, National Veterans Affairs and Rehabilitation Commission, The American Legion; Mr. Larry Rhea, Deputy Director of Legislative Affairs, Non Commissioned Officers Association; and Mr. Richard Weidman, Director of Government Relations, Vietnam Veterans of America, on behalf of the National Military Veterans Alliance.

On April 5, 2000, the Subcommittee on Health received testimony on the issue of Veterans Health Administration capital asset planning. Among those testifying at that hearing were the Honorable Dave Weldon, Member of Congress from the State of Florida; Mr. Stephen P. Backhus, Director, Veterans' Affairs and Military Health Care Issues, Health, Education, and Human Services Division, General Accounting Office, accompanied by Mr. Paul Reynolds, Assistant Director, Veterans' Affairs and Military Health Care Issues, Health, Education, and Human Services Division, General Accounting Office; and Mr. Walter Gembacz, Assistant Director, Veterans Affairs and Military Health Care Issues, Health Education, and Human Services Division, General Accounting Office; Dr. Frances M. Murphy, Acting Deputy Under Secretary for Policy and Management, Department of Veterans Affairs; accompanied by Dr. Terrence S. Batliner, Director, VISN 19; Mr. Dennis Smith, Director, VA Maryland Health Care System; Charles V.

Yarbrough, Chief Facilities Management Officer, Department of Veterans Affairs; Mr. Gordon H. Mansfield, Executive Director, Paralyzed Veterans of America; Mr. Dennis M. Cullinan, Director, National Legislative Service, Veterans of Foreign Wars; and Mrs. Jacqueline Garrick, Deputy Director, National Veterans Affairs and Rehabilitation Commission, The American Legion.

On April 12, 2000, the Subcommittee on Health received testimony on the issue of recruitment, retention, and compensation of the VA health care workforce. Those testifying at this hearing included: Mr. Kenneth J. Clark, Chief Network Officer, Department of Veterans Affairs; accompanied by Mr. Walter A. Hall, Assistant General Counsel, Mr. Thomas J. Hogan, Director Management Support, Ms. Mari A. Horak, Management Support; Ms. Margaret Kruckemeyer, President, Nursing Organization for Veterans' Affairs (NOVA); Mr. Bobby Harnage, National President, American Federation of Government Employees; Dr. John F. Burton, National Association of VA Physicians and Dentists, and Dr. Robert M. Anderton, American Dental Association.

On May 17, 2000, the Subcommittee on Health received testimony on the issue of Health Care Sharing programs of the Departments of Veterans Affairs (VA) and Defense (DoD). Among those testifying at this hearing included: Mr. Anthony J. Principi, Chairman, Congressional Commission on Servicemembers and Veterans Transition Assistance, Mr. Stephen P. Backhus, Director, Veterans Affairs and Military Health Care Issues, Health, Education, and Human Services Division, General Accounting Office; the Honorable Thomas L. Garthwaite, Deputy Under Secretary for Health, Department of Veterans Affairs; Gwendolyn Brown, Deputy Assistant Secretary of Defense, Health Budgets and Financial Policy, Department of Defense; and Lieutenant General Paul K. Carlton, Jr., Surgeon General, United States Air Force.

On the basis of its hearings and oversight on these matters, the Subcommittee on Health met on September 7, 2000, to mark up H.R. 5109, the Department of Veterans Affairs Health Care Personnel Act of 2000. The bill was endorsed unanimously by the Subcommittee and reported to the full Committee on Veterans' Affairs. The full Committee met on September 13, 2000, and ordered the bill reported, as amended, favorably to the House.

## SUMMARY OF THE REPORTED BILL

*H.R. 5109 would*:

### TITLE I—PERSONNEL MATTERS

1. Authorize annual "national" comparability pay raise for VA nurses on par with that of other federal employees.
2. Make optional annual locality survey process for VA nurse pay. Define "triggers" that indicate the need for Directors to perform locality pay surveys for nurses such as turnover, lag time, looming nurse shortage, to be defined in criteria of Secretary; require communication to peer and senior Veterans Health Administration (VHA) management of intent to survey; report to Congress on decision to survey.
3. Eliminate the sole discretion vested in facility directors to make pay decisions; clarify that the absence of a nurse re-

cruitment or retention problem not be a basis for failure to provide a pay increase; prohibit "negative pay adjustments"; authorize the use of independent survey results; and provide, to the extent practicable, for pay surveys to collect actual salary and benefits data.

4. Provide for nurse participation in policy and decision-making at the network and medical center levels.
5. Revise and increase the rates of special pay (in addition to base pay) which is provided to dentists employed by the Veterans Health Administration.
6. Add pharmacists to the occupations that are exempt from a statutory cap on special salary rates that may be paid to meet documented staffing problems.
7. Require that the Under Secretary for Health: (a) designate a physician assistant (PA) to serve as a consultant to the Under Secretary and (b) seek the advice of a PA consultant on all matters relating to the employment and utilization of PAs in the Veterans Health Administration.
8. Authorize temporary appointments of up to two years for PAs who have successfully completed the full course of training for that profession and are pending certification.
9. Authorize temporary extensions of term appointments for medical support personnel in VA-funded research projects.
10. Authorize the Secretary to waive state licensure requirements for VA social workers while they are completing training.
11. Extend and modify employee "buyout" legislation through December 31, 2002.

TITLE II—CONSTRUCTION AUTHORIZATION

1. Authorize the Secretary to construct and authorize the appropriation of $102 million in fiscal year 2001 or 2002 for major construction projects (a psychogeriatric care building at the Palo Alto, CA VA Medical Center; a utility plant at the Miami, FL VA Medical Center; and seismic improvements at the Long Beach, CA VA Medical Center).
2. Authorize previously appropriated but not authorized, long-term care psychiatric facility at the Murfreesboro, TN VA Medical Center.

TITLE III—MILITARY SERVICE ISSUES

1. Require that, in conducting an initial clinical evaluation of a veteran, VA identify and document pertinent military experiences and exposures, which may contribute to the health status of the patient.
2. Require that VA enter into a contract with an appropriate entity to carry out a study on post-traumatic stress disorder in follow-up to the study on that disorder conducted under section 102 of Public Law 98–160.

TITLE IV—MEDICAL ADMINISTRATION

1. Authorize VA to conduct a four site pilot program involving coordination of VA and non-VA health care benefits; (a) limit program to $50M/year total expenditure; (b) authorize VA to

include veterans without other health care benefits; (c) set a delimiting date of September 30, 2005, for the demonstration; (d) limit the "scope of services" to basic medical-surgical care; and (e) require reports to the Veterans' Affairs Committees.

2. Provide compensation under section 1151 of title 38, United States Code, (with consequent health care coverage under chapter 17) to a veteran who is injured as a result of participation in a VA compensated work therapy program.
3. Extend through 2005, VA's authority to establish nonprofit foundations to foster research, education, or both, in VA medical centers.
4. Authorize VA to furnish veterans and others accompanying veterans with temporary lodging (Fisher Houses) in connection with treatment or other provision of services.
5. Extend the requirement that VA maintain a special committee relating to the care of the seriously chronically mentally ill.
6. Facilitate VA establishment of VA outpatient clinics in State veterans' homes.
7. Modify the congressional reporting requirement for a proposed enhanced use lease that requires VA to wait "60 legislative days" to "90 calendar days."
8. Release a reversionary interest of the United States in certain property previously conveyed to the State of Tennessee for use by the Army National Guard.

## BACKGROUND AND DISCUSSION

### NURSE PAY

Congress in 1990 enacted a law (the Department of Veterans Affairs Nurse Pay Act of 1990, Public Law 101–366) which completely restructured the VA pay system for nurses to remedy a serious recruitment and retention problem documented at that time. The legislation was sparked by a nationwide shortage of nurses which, under the constraints of then-applicable law, left VA at a marked competitive disadvantage in hiring and retaining registered nurses.

The 1990 nurse pay act established a flexible authority for VA medical center directors to set pay rates for nurses, based on the local labor market. (Pay adjustments were to be based on data from the Bureau of Labor Statistics, or if unavailable, on data from locally administered surveys). The act replaced a system in which basic pay could only increase within a specified pay range (for each of then eight nurse-pay grade levels), and in accordance with annual government pay increases. "Special salary rates" could be set to respond to recruitment/retention problems but only through a cumbersome headquarters-administered process. The new system allowed for substantial pay increases tied to starting salaries for nurses in the local community. The law also limited the extent of locality pay adjustments to preclude VA from becoming a community *pay-leader* (specifying that the minimum rate of basic pay for any grade would not exceed the beginning rate of pay for corresponding positions at non-VA facilities) and divorced nurse pay from the pay system governing other VA employees. Nurses' organizations supported this legislation, though it had both positive and negative aspects. By linking pay to compensation in the local pri-

vate sector, the system offered the potential for substantial pay increases. By severing that system from the pay mechanisms of the General Schedule pay system under which other medical care personnel are paid, however, it left nurses without the assurance of annual pay increases other employees received.

As an early result of this pay act, nurses in many locations received very substantial pay increases which were not given other health care personnel. In 1991, for example, when the General Schedule increase was 4.1 percent, the minimum pay rates for entry and intermediate level nurses at the Washington, DC VA Medical Center jumped more than 59 and 35 percent, respectively. With the passage of years, however, nurses in certain grades and in certain areas of the country experienced substantially smaller pay increases than other VA employees under the General Schedule system. In some instances, nurses received no locality pay increases for two or more years.

Overall, VA reports that nurse salaries have generally tracked U.S. nurse salaries at large. But those salaries reflect marked variability across the country. Current salaries for beginning VA nurses at "grade 1, step 1" range from a high of approximately $49,000 in San Francisco to salaries from $25,000 to $30,000 in many locations; in many other major metropolitan areas those salaries range from $35,000 to $45,000. Those in the first step of "grade 2" range from approximately $57,000 in northern California to salaries from $35,000 to $40,000 in many locations. At the "grade 3" level, VA nurse salaries begin above $60,000 in several locations (to a high of about $63,000). The last three years have seen a steady increase nationally in the percentage increase in adjustments to nurse pay, with a national average increase of 2.2 percent, 3 percent, and 4.3 percent, in January of 1998, 1999, and 2000, respectively. The average increases for the preceding two years were 1.2 percent and 1.3 percent, respectively. General Schedule increases for these years, however, outpaced nurses' average increases.

In light of concerns about administration of the locality-pay system, in June 1998, VA entered into a contract for a study to identify how well the locality pay system (LPS) is working, and what could be done to improve the system. Anticipating that study, Congress in November 1998, in Public Law 105–368, directed VA to furnish its findings regarding the locality pay system and provide recommendations to Congress by February 1999 for administrative and legislative action. The Secretary of Veterans Affairs ultimately submitted a report to Congress in December 1999. That report, however, did not make legislative recommendations. While acknowledging problems with the manner in which the locality pay system had operated, in testifying before the Subcommittee on Health, VA offered neither a legislative nor an administrative remedy, nor any timetable for presenting or implementing the contractor's recommendations.

VA has generally agreed with the findings reported by its contractor, that when first implemented, LPS helped VA efforts to recruit and retain nurses. In subsequent years, however, a reduction in nurse staffing in the non-Federal sector has markedly changed the labor market. The contractor reported that recruitment for nurses did not appear to be a major problem for VA medical cen-

ters, and retention of VA nurses appeared to be even less of a problem. The design, operation, and administration of the LPS system were seen to represent challenges, however. The report identified several problems associated with conducting locality-pay surveys. For example, approximately two-thirds of VA medical centers reportedly experienced significant problems in obtaining pertinent salary information from non-VA hospitals. The contractor identified as a "fundamental problem" the fact that the LPS process focuses on beginning rates of pay, which may not give a full or completely accurate view of appropriate compensation levels. Industry practice reportedly is to begin with midpoints for a range and set the boundaries of the range at 20 percent or more above and below the midpoints; thus, non-VA facilities may never actually pay at the "beginning" rate of the range.

The report also addressed the question of how well the compensation system was working, and found only one of five indicators to be problematic, involving "internal equity." It identified several factors contributing to morale problems. First, nurses may or may not receive an increase in a given year, depending on the results of LPS and the judgments of VA medical center directors, while their General Schedule-paid co-workers receive annual pay increases and private sector nurses generally receive cost-of-living or similar increases every year. Second, many believe that budget constraints have a direct and negative affect on pay increases. Because hospital directors have exercised their discretion to provide pay raises so variably across the system, nurses perceive their pay system to be "unfair."

The study recommended that the LPS survey administration reflect private industry practice. For example, the study recommended use of independent, third-party surveys; acquiring data on averages and ranges, as opposed to beginning pay only; surveying hospitals on actual pay rather than published minimums; and doing job analysis and detailed job matching on a less than annual basis, using standard industry terms and definitions.

In light of finding wide variability in VA medical center directors' interpretations and implementations of the LPS law, the study recommended that VA establish more checkpoints for the validity, reasonableness, and fairness of the pay adjustment decisionmaking process. It further recommended that VA Headquarters communicate these checkpoints frequently to directors. The study also made a "longer-term" recommendation for the pay-setting process—to establish two separate components for annual pay adjustment, a general across-the-board pay adjustment for all VA nurses and a locality based differential that reflects local market conditions or cost-of-living differences. Insofar as the latter element is characterized in the study as "retain[ing] the key feature of the current VA LPS that permits nurse pay at VA facilities to be competitive with pay at local non-VA health care facilities," the Committee believes that the recommendation is worthy as an alternative to the current LPS.

For the past three years, at the urging of Congress, VA's Under Secretary for Health has strongly encouraged facility directors to grant pay increases to prevent pay-related staffing problems. Even under that invigorated policy, however, nurses' average pay in-

creases over the past five years still have lagged behind the General Schedule increases. In addition, the VA has yet to make other administrative changes recommended by the contractor.

To respond to these continuing problems, the Honorable Steven C. LaTourette introduced H.R. 1216, the "Department of Veterans Affairs Nurses Appreciation Act of 1999." This bill would require that VA provide the same General Schedule pay raises for nurses and certain other health-care professionals employed by the Department of Veterans Affairs as it provides to other federal employees, and would revise the authority of the Secretary of Veterans Affairs to make further locality pay adjustments for those employees. Mr. LaTourette's advocacy in the VA nurse pay issue, and particularly the introduction of H.R. 1216, encouraged the Committee to require an annual "national" comparability pay increase for VA nurses. Also, the Committee bill rescinds the mandatory annual locality survey process governing VA nurse pay.

Instead of a mandated survey process, the bill requires each VA health care facility to complete an annual report with information on turnover and vacancy rates in nurse staffing, including a comparison of these rates with those of the preceding three years. If a director of a VA health-care facility using objective criteria established by the Secretary determines that no current recruitment or retention problems exist, he or she may decide not to survey that year. This decision, however, must be explained to the Under Secretary and reported to Congress. The VA Under Secretary for Health, however, may also question and override the decision of the local director. Alternatively, if a director determines that there is a current or pending problem with recruitment and retention of VA nurses, the director may, after informing local and regional directors, activate the wage survey process. The VA Secretary will also report to Congress on these matters. The Committee believes that providing a guaranteed annual comparability pay increase and a means of providing competitive wages in tight local labor markets for nurses, as well as required oversight and reporting, will solve this longstanding problem raised by VA nurses.

The reported bill requires VA network officials and VA medical center directors to consult with VA nurses in matters of allocation of resources, quality and other aspects of health policy. It requires VA directors to appoint registered nurses to local policy committees to ensure that the nursing perspective is considered in formulating recommendations affecting the delivery of health care in VA facilities.

### DENTAL PAY

Section 7439 of title 38, United States Code, ensures that Congress establish levels of total pay for physicians and dentists of the Veterans Health Administration that are reasonably comparable to levels of total pay for other federal and non-federal physicians and dentists. That policy is intended to ensure that VA recruits and retains a well-qualified work force of physicians and dentists. To that end, the law requires the Secretary of Veterans Affairs to report to the President on a quadrennial basis on recruitment, retention, and compensation of VA physicians and dentists, and to recommend appropriate rates of special pay adjustments when appropriate or nec-

essary. The President is to include such recommendations on rates of special pay changes in the budget.

The last substantial changes to physician and dental special pay authorities were enacted in 1991 in the Department of Veterans Affairs Physician and Dentist Recruitment and Retention Act of 1991, Public Law 102–40. With that law, Congress modified provisions established in 1975 when it first provided for supplementing the pay of certain VA physicians and dentists with "special pay" and "incentive pay" to improve the hiring and retention of these clinicians. A rapid rise in pay during the 1980s created new problems for VA in recruiting and retaining certain physicians and dentists, particularly specialists in these fields, and led to adoption of the 1991 Act.

The 1991 act authorized VA to pay physicians and dentists supplementary amounts of pay (above base pay rates) in exchange for their agreements to work for specified terms of years. "Special" pay could be paid (within specified pay ranges) for any of the following: full-time status, tenure, supervisory or executive responsibilities, exceptional qualifications, scarce specialty status, and geographic location. This special pay authority was intended to give the agency flexibility to respond to local labor market conditions. At the time, recruitment and retention of dentists did not pose as significant a problem for VA as physicians did and, accordingly, the Act provided lesser amounts of special pay in most categories for VA dentists.

In its most recent (1999) quadrennial report to the President, VA reported that pay for physicians is comparable to physicians in other federal agencies and is reasonably comparable to that of physicians in the uniformed services. In light of the reported effectiveness of decentralized authority on pay decisions, the ability to offer competitive compensation packages, and ongoing restructuring of its professional work force, VA found no need to propose changes in VA physician pay. However, while concluding that "the existing pay system is working for physicians," the report acknowledged a dentist pay problem.

> VHA is starting to experience difficulty in recruiting and retaining dentists. Most of this difficulty is focused on VHA's inability to offer adequate financial incentives due to the limitations of dental special pay. During the five-year period starting in 1995, VHA experienced a decline in full-time dentists from 830 to about 677 while the annual turnover rate has been running in excess of 11 percent. There are also fewer "highly qualified" applicants to fill vacant positions and most vacancies take several months to fill. During this same period, income levels for dentists in the private sector have increased to an average of $130,000 per year, versus an average base pay of $95,000 per year for VA dentists. In addition, Congress recently passed legislation that provided accession bonuses of $30,000 for newly appointed military dentists while at the same time increasing tenure pay to an amount up to $18,000 per annum."

In that report, VA recommended an increase in "full-time pay" for dentists (from $3,500 to $9,000) as "a modest response to a developing problem," and also proposed to increase the pay ranges for dental executives to those of their physician counterparts. As the report noted, lack of a significant pay increase for dental executives "has been a financial disincentive to dentists assuming positions of added responsibility, has hindered recruitment for these positions, and has been cited as the reason for the resignation of several dental service chiefs."

There are relatively limited data to document the extent of dentist recruitment and retention problems because many VA medical center directors apparently have not attempted to fill position vacancies. Nevertheless, in testifying before the Subcommittee on Health on April 12, 2000, VA acknowledged that almost seven in ten VA dentists will be eligible to retire by 2003. With VA dental specialists' salaries averaging $104,959 per year (as of September 30, 1999), including incentives, and with pay of VA dentists in general practice averaging $102,063, including incentives, the Committee concluded that VA dentist pay is significantly below that of the uniformed services and far below community levels. In capsule, VA's dentist pay problem was summarized at the April 12 hearing as follows:

> Mr. SIMPSON: ". . . if 70 percent of the dentists in the VA system are going to retire within the next three years, or eligible for retirement within the next three years, we're going to have serious problems in trying to recruit dentists, even though you suggest that we might not have that problem now. Over the next two years, it is going to become a real problem, especially when the rate of dental school graduates is decreasing, and the environment in the private sector is so much more advantageous for those people to enter into private practice.

Although VA, in its report to the President, recommended changes in two components of special pay, it is questionable whether those changes alone would adequately address either the recruitment or retention problems identified at the hearing. Neither, for example, addresses the concern that VA no longer attracts dentists with sufficient experience to work effectively with VA's unique patient population. The reported bill, accordingly, would provide special pay targeted to the first two years of employment of dentists who have successfully completed post-graduate hospital-based training. The reported bill would also provide greater amounts of special pay in recognition of the greater experience acquired over years of service. VA policy as set under current law limits a dentist in (what some might view as) the prime of his or her career to tenure pay of only $3,500 and a maximum after 19 years service of $4,000. The reported bill would significantly increase these levels, as well as other key components of dental special pay, to ensure that VA can meet its recruitment and retention goals.

### PHARMACISTS' PAY

Under section 7455 of title 38, United States Code, VA has authority to increase rates of basic pay—either nationally, locally or

on another geographic basis—when deemed necessary for recruitment and retention of certain health care personnel. The grant of special rates is based on documented staffing problems, to include turnover, resignations based on pay, and inability to fill vacancies.

With limited exceptions, the law limits such "special salary rates" to a maximum, expressed as twice the difference between the high and low basic pay levels for the particular grade. (That maximum is the equivalent of the 28th pay step for the particular grade.) It is noteworthy, however, that Congress has exempted two categories of health care personnel from that statutory ceiling: nurse anesthetists and physical therapists.

The Subcommittee on Health, in a recent survey and site visits, has considered reports of severe difficulties in recruitment and retention of pharmacists. The Committee understands that significant competition to hire and retain pharmacists is hampering VA's efforts to staff its pharmacies adequately. Competition from retail pharmacies has already prompted VA to increase salaries. As of April 30, 2000, VA reported that 176 special salary authorizations for pharmacists had been granted covering 3,762 individuals. Accordingly, 86 percent of the 4,384 pharmacists employed by VA as of that date were being paid special salary rates. In the first four months of this year alone, VA implemented 48 new or increased pharmacist special rate authorizations. The number of special rate authorizations at or within six percent of the step–28 limit increased by 12 in just over one month—from 73 as of March 28, 2000 to 85 as of May 3, 2000.

Anticipating that, absent relief, these trends will continue to plague VA's retention and recruitment of pharmacists, the Committee has included language in this bill that will add VA pharmacists to the two existing categories of VA personnel exempted from statutory pay ceilings.

PHYSICIAN ASSISTANT CONSULTANT

Physician assistants (PAs) have been employed in the VA health care system since 1970. Physician assistants are utilized in both inpatient and outpatient settings working in virtually all medical specialties. VA is the largest American employer of PAs with nearly 1,200 PAs employed throughout the system. PAs are being utilized extensively as physician extenders, and VA has acknowledged its need to employ still more PAs to staff the growing number of VA outpatient clinics.

VHA is administered by an Under Secretary for Health who, with chief consultants leading various strategic healthcare groups, formulates VA health care policy. The VA Committee envisions that a PA consultant would participate in these policy discussions regarding personnel issues, recruitment and staff development, education, clinical practice issues, and health care strategic planning. Most recently, in December 1999, the VA Committee Chairman and Ranking Member wrote the Deputy Under Secretary for Health urging VA to establish such a position. VA's response in February 2000 stated that physician assistants in VA are currently represented by the Chief Consultant of Primary and Ambulatory Care, who coordinates with a physician assistant field advisory group.

Despite employing PAs for nearly 30 years, the VA does not employ a representative of the PA practice within VHA to advise the administration on the optimal utilization of PAs. Without this expertise, VHA has placed restrictions on the ability of VA physicians to effectively use PAs. The Committee has concluded that VHA is not fully utilizing a valuable resource for providing cost-effective health care, especially primary care as practiced in so many of the VA community-based outpatient clinics.

The reported bill would create a PA consultant position held by a VHA physician assistant who would serve as a consultant to the Under Secretary for Health. The Committee expects the Under Secretary to use this authority to address many problems reported by VA PAs that would improve the delivery of health care.

TEMPORARY APPOINTMENTS FOR PHYSICIAN ASSISTANTS

Under current law (section 7405(c)(2) of title 38, United States Code), VA has authority to provide temporary appointments of up to two years to individuals in certain professions (nursing, pharmacy, and respiratory, physical, and occupational therapy) who have successfully completed a full course of study and who are pending registration, licensure, or certification. Upon obtaining the required credentials, these professionals are converted to career appointments. The initial temporary "graduate technician" experience can be credited toward meeting grade level requirements for promotion within an occupation. The temporary appointment authority provides VA a means of recruiting health professionals while they are meeting the technical qualification standards.

VA plans to double the number of PAs it employs within the next several years. Nevertheless, VA has far less flexibility in hiring physician assistants in training than it does nurses. The only basis for employment of a physician assistant who is waiting to take the certification examination is a one-year, nonrenewable appointment. A one-year appointment limits VA's efforts to recruit candidates. Moreover, since the physician assistant national certification examination is only given twice yearly, an individual often has only one opportunity to take the examination during the course of his or her one-year term appointment. Even highly qualified individuals are reluctant to accept a VA position under these circumstances.

The reported bill would amend section 7405(c)(2) to enable VA to provide temporary graduate technician appointments to physician assistants who have completed approved training programs on the same basis as for VA nurses and other professionals. Graduate physician assistants would have up to two years to seek and obtain professional certification. This change should help VA's recruitment efforts for this important occupation.

SOCIAL WORKER LICENSURE

Public Law 102–86 requires a VA social worker to be licensed, certified, or registered *in the State* in which he or she works in a VA facility, within three years of initial appointment in this capacity by VA. Certain states such as California require challenging prerequisites to the licensure examination that routinely require more than three years for individuals to complete. Many states do not work reciprocally, and thus will not grant a license unless a so-

cial worker takes the state licensing examination. At present, VA social workers are the only VA health care practitioners who cannot use their state licenses to gain credentials in other states' VA medical centers. As a consequence, in the State of California, for example, 68 VA social workers face termination of employment or significant position downgrades because of failure to meet this three-year licensing requirement. VA social workers in Louisiana are concerned as well, and this problem may occur in additional states as yet unidentified. The Committee believes, notwithstanding the fact that VA first proposed the three-year licensure requirement, that VA should have additional flexibility in managing its social workers. Therefore, the reported bill would provide for the VA Secretary's waiver of the licensure requirement to enable social workers to complete their training preparatory to state licensure examinations.

EXTENSION OF VOLUNTARY SEPARATION INCENTIVE PAYMENTS

The Veterans' Millennium Health Care and Benefits Act, Public Law 106–117, authorized the Secretary of Veterans Affairs to offer employees voluntary separation incentives "buyouts" of up to $25,000 each, in order to restructure operations and functions identified in a plan designed to improve operating efficiency and quality of care. The bill continues to require a one-for-one exchange—in other words, VA must hire one employee for every employee offered a buyout. VA has sought replacement employees for 94 percent of the positions for which it offered buyouts under its current authority, which expires on December 31, 2000. VA made an informal request late in this Congress for a three-year extension of this authority.

In considering VA's request, the Committee notes that VA stands alone among agencies in being required to make to the federal civil service retirement fund a contribution of 26 percent of an employee's average highest three-year salary as a type of premium paid to the fund to cover its added costs incurred from these particular retirements. However, a Committee inquiry to the Office of Personnel Management yielded information leading the Committee to conclude that this rate represents an overpayment by VA. The OPM actuarial forecast that was used previously to derive the 26 percent payment was based on an "early out" analysis, not a buyout basis. The Committee observes and VA has documented that most VA employees who have participated in the voluntary separation program to date were either already eligible for voluntary retirement on the basis of length of service, or shortly would have been so eligible. Other agencies participating in the buyout program contribute at the 15 percent level for the "high-three" average salary years. Based on all the efforts of Congress in the 1998–99 period to restore VA medical care funding, and given that most of the buyouts to date emanated from the Veterans Health Administration, the Committee believes that there is no basis for requiring VA to make a higher payment than other agencies to the retirement fund.

The reported bill would provide an extension of VA's buyout authority until December 31, 2002, a two-year extension rather than the three years requested informally by VA. The Committee will

closely monitor VA's use of buyout authority to ensure that the qualitative base for delivering health care to veterans is not eroded by VA's use of this authority.

MILITARY SERVICE HISTORY

The Committee recognizes and applauds the leadership of the Veterans Health Administration for initiating efforts to incorporate a military history into the scope of a comprehensive medical examination. Left unidentified and untreated, conditions which have their origins in military service not only portend severe consequences for a patient's health, but represent the very essence of what a veterans' health care system was intended to detect and rehabilitate. Ascertaining that a veteran was a prisoner of war, participated in combat, or was exposed to sustained subfreezing conditions, toxic substances, or environmental hazards or nuclear ionizing radiation, for example, are of critical diagnostic and treatment relevance. The Committee views the taking of a thorough history, to include a military medical history, to be so central to VA's mission that it has included this requirement in the reported bill. While VA has stated its support of this effort, progress in implementing it has been slow. This Committee has historically respected, and repeatedly declined invitations to direct, clinicians' practice of their professions. Yet there is both value and importance in recognizing and affirming the wisdom of ensuring that a military medical history be a mandatory component of every veteran's VA care. The reported bill would provide assurance that such a policy becomes a matter not only of administrative policy but also everyday clinical practice in VA.

POST-TRAUMATIC STRESS DISORDER STUDY

In 1984, the VA began a large-scale survey on the prevalence and incidence of post-traumatic stress disorder and other psychological problems among Vietnam veterans. That study, directed by Congress in Public Law 98–160, involved a representative sample of all Vietnam theater and era veterans who served between August 1964 and May 1975. The study found that at the time some 15 percent of male and 8.5 percent of female Vietnam theater veterans suffered from post-traumatic stress disorder (PTSD). Among those exposed to high levels of war zone stress the rates were dramatically higher—fourfold for men (a rate of almost 35.8 percent) and sevenfold for women (a rate of 17.5 percent)—than rates for those with low to moderate stress exposure. Some 31 percent of males and 27 percent of female Vietnam theater veterans were found to have suffered from PTSD at some point after their military service.

The VA study was recognized as a landmark investigation that provided definitive and unique information on the prevalence and etiology of PTSD. The study results led VA to develop specialized programs to treat those veterans suffering from this condition. Because of the high rates of PTSD and strong evidence of its persistence, experts have cited the importance of initiating a follow-up study involving those who participated in the original work.

Recent studies have documented that PTSD is an important determinant of continued disability and need for care. PTSD has been shown to be strongly associated with a range of other mental

health diagnoses, social and adjustment problems, including substance use disorders, and with high consumption of VA health care resources. Given its chronicity and association with long-term disability, the proportion of VA resources required to meet the needs of veterans with PTSD may increase over the coming years. To help VA prepare to meet such a need, it must have a better understanding of whether PTSD is a risk factor for later health problems which may yet emerge in this still comparatively young population. A follow-up study of the National Vietnam Veterans Readjustment Study would provide a valuable, cost-efficient mechanism to answer important questions such as:

(1) What is the impact of PTSD on subsequent medical morbidity? There is suspicion, for example, that PTSD could be a risk factor for cardiovascular disease. A follow-up of findings from the original study coupled with physical examinations and more extensive data collection on physical health problems would permit VA to collect valuable information that could help plan for veterans' future needs for medical services.
(2) What is the long-range course of PTSD? Follow-up interviews would allow an estimate of remission and relapse rates, and identification of risk factors that affect the course of the syndrome.
(3) What are the psychological and psychiatric consequences of PTSD?
(4) What subgroups of veterans are least likely to recover from PTSD and most likely to suffer effects of PTSD in other aspects of their health and functioning?
(5) What VA health care services do veterans with PTSD use and what impact has such use had on the course of the disorder?

Scientists who have conceived such a follow-up study envision that it would involve re-interviewing the approximately 2,350 theater and era veterans who participated in the original study, and that a portion of the study population would undergo a standardized physical examination, psychiatric assessment, as well as a review of their medical and treatment records. It is anticipated that the cost of this study would be a fraction of the original, longer $10 million study. The Committee believes that VA, with the close involvement of its National Center for Post-Traumatic Stress Disorder, should design this project. Based on the earlier understanding that the study's subjects not be identifiable by the government, the study should be conducted by an independent contractor.

ENHANCED USE LEASE PROGRAM

Congress, in the Veterans' Millennium Health Care Act, Public Law 106–117, eased limits in law on leasing underused VA property based on a finding that long-term leasing could be used more extensively to enhance health care delivery to veterans. In an April 5, 2000, hearing before the Subcommittee on Health on VA capital asset planning and management, the General Accounting Office reiterated its earlier-expressed view that VA could improve veterans' health care if it reduced the level of resources spent on underused, inefficient, or obsolete buildings and reinvested those savings in providing health care more efficiently in modern facilities at exist-

ing or new locations closer to where veterans live. A survey of VA facilities conducted by the Subcommittee earlier this year revealed that many facilities have unneeded buildings or land with potential for long-term leasing and commercial development. The years-long approval process was frequently cited as a significant disincentive for potential private sector lessees.

The Committee has written to the Secretary of Veterans Affairs to encourage the Department to streamline its approval process. The Secretary has as yet failed to act on the Committee's initiative. Statutory requirements, however, to include a requirement for public hearing and Congressional notice also delay development and execution of such leases. The Committee's review of those statutory requirements suggests that, with the maturing and demonstrated success of this program, it is appropriate to consider relaxing safeguards which were imposed at its inception, but which now may no longer be necessary. Therefore, in this bill, the Committee has included language reducing the waiting period after VA notifies Congress of the intent to execute an enhanced use lease from 60 "legislative days" to 90 "days."

TEMPORARY LODGING AT VA HEALTH CARE FACILITIES

Fundamental changes in VA health care delivery over the past 20 years have dramatically increased the number of medical procedures being performed on an outpatient basis at VA medical centers. Because of the lengthy travel required to undergo needed tests and procedures, VA's patients occasionally need overnight lodging. For example, patients, who may live hours from a VA medical center, often must be at that center early in the morning to undergo a procedure and to be sent home later the same day. Transportation problems may require a patient, often accompanied by a family member, to arrive the night before a procedure. It is also common for a patient to require a series of outpatient visits over a short period of time, none necessitating a hospital admission. Thus, for example, a patient might have surgery on an outpatient basis and be required to return to the clinic for follow-up care the next day. Such situations can present great difficulties for often elderly patients with limited financial means who must travel long distances to obtain outpatient care, but who lack the means to procure local accommodations. While VA's establishment of hundreds of new community-based outpatient clinics has helped ameliorate the problem, many patients must still travel significant distances for diagnostic testing, specialty care, or surgery. In an effort to meet patients' needs, VA medical centers have for some years made efforts to assist patients and family members accompanying them in finding overnight accommodations. Similar efforts are made by many non-VA medical facilities that serve a geographically-dispersed patient population.

The Committee is aware that VA has tried to meet the needs of veterans for accommodations in various ways. One alternative has been the establishment of facilities known as "Fisher Houses," built with funds donated by the Zachary and Elizabeth M. Fisher Foundation. Four such facilities are now being operated in conjunction with VA medical centers. The Committee is also aware that many VA medical centers over the years have converted unused wards

and other available space to establish temporary lodging facilities for use by patients. In fact, VA has encouraged medical centers to establish such facilities as an alternative to hospitalizing patients when outpatient treatment is more appropriate. In 1996, the Under Secretary for Health issued VHA Information Letter 10–96–028 to provide guidance on the requirements for operating these facilities, which the Under Secretary named as "hoptels." The guidance provided that VA facilities could provide lodging without charge to outpatients and family members accompanying the veteran when medically necessary. The guidance also sanctioned the use of a revocable license for family members under which the individual would be required to pay VA a fee equal to the fair market value of the services being furnished.

It is the Committee's understanding that most VA medical centers now offer patients in need help with some form of hoptel or lodging facility. Indeed, VA has informally advised the Committee that more than 115 facilities offer lodging of some kind on VA grounds, and that services are available in non-VA facilities at a number of other locations. It is not at all clear, however, that these facilities are operated in strict compliance with the guidance provided in the 1996 Information Letter.

The reported bill would provide clear authority for VA to provide such temporary overnight accommodations in Fisher Houses and other similar facilities located at or near a VA facility, when it is appropriate to do so. These accommodations would be available to veterans who have business at a VA medical facility and must travel a significant distance to receive Department services, and to other individuals accompanying veterans. The bill would also give VA clear authority to charge for overnight accommodations and apply the fees collected to help support these services. The bill contemplates that VA will promulgate regulations to address such matters such as the appropriate limitations on the use of the facilities and the length of time individuals may stay in the facilities.

PILOT PROGRAM ON COORDINATION OF BENEFITS

The VA health care system has undergone a profound transformation in recent years. Among the changes in VA health care is a marked improvement in veterans' access to care. In contrast to the hospital-centered system of years ago, many veterans no longer rely exclusively on VA hospitals for routine health care delivery, but increasingly have access to VA community-based clinics that provide primary care and sometimes additional services within reasonable distances of their homes. The proliferation of such clinics, however, has not necessarily eased access to *hospital care* when hospitalization is required.

The remarkable success of a pilot program in east central Florida has sparked development of a model which could improve veterans' access to needed inpatient care. In appropriating funds for VA medical care for fiscal year 1998, Congress earmarked $5 million for this pilot program. (The earmarking followed Congressional rejection of a VA proposal to construct a new VA hospital in that area, and appropriation of funds instead to construct a community-based VA clinic.) The pilot program was designed to explore the cost effectiveness of meeting veterans' needs for hospital care in

their own communities. It also provides an alternative to veterans traveling considerable distances to receive VA hospital care.

In June 1997, an interim primary care clinic was opened in Palm Bay (Brevard County), FL, pending completion of the new Brevard County clinic in Viera, FL, which opened in July 1999. The east central Florida pilot program outlined above (ECF pilot) was initiated in June 1998. Under the pilot, veterans residing in Brevard County who were enrolled and referred for services in the Palm Bay clinic and who did not have specialty needs were given a choice of receiving any needed hospital care at VA expense at the Tampa or Palm Beach VA medical centers or in a private sector hospital. The pilot program operated from July 1, 1998 to June 30, 1999.

An independent study of the pilot program, discussed at the Subcommittee's hearing on April 5, 2000, found that the veterans who participated in the ECF pilot were generally comparable in age and illness experience to Brevard County and non-Brevard County veterans who were not eligible for the pilot and were hospitalized at VA facilities in Tampa and Palm Beach. These patients were enrolled in a primary care clinic which indicated that they did not have conditions that required ongoing treatment by specialists. This eliminated many veterans with chronic disabilities and ensured that most of the care these veterans received was for acute conditions. Patient satisfaction among participants was generally high. Pilot participants who were hospitalized in contract facilities had a much shorter length of stay than that of veterans hospitalized in VA facilities. The study indicates that overall inpatient costs for the ECF pilot were about 28 percent less than the VA hospitalized groups. According to the report, "[t]here is reason to believe that private sector contracting might be the most cost-effective approach to veteran care in areas where there is no VA hospital presence and many underutilized private sector hospitals." The report estimated that the cost of extending the pilot program for an additional five years would increase from $5 million to more than $35 million annually.

While the ECF pilot has demonstrated success, further extending or expanding a contract program is not the only way to apply "lessons learned" from this experience. The Committee takes note, for example, that many veterans who obtain care from VA have other health plan coverage. The ECF pilot demonstrates that in areas of the country in which VA does not operate a hospital, a VA clinic can coordinate veterans' care. There is no precedent, however, for VA's coordinating payments among external plans and payers.

The reported bill would authorize a pilot program involving coordination of hospital benefits which could operate in up to four locations. Under such a program, veterans with Medicare or other health plan coverage who rely on a nearby VA clinic for care but reside far from the nearest VA medical facility could make a choice when VA finds that they need hospital care. Veterans who are reluctant to travel hundreds of miles to a VA facility could elect to receive care at a community hospital as a Medicare or other health plan beneficiary. The VA clinic would still coordinate the care. To ensure that the patient does not incur additional out-of-pocket costs, the reported bill provides that VA would cover copayments

required by an individual veteran's health plan. The experience of the Florida pilot program strongly suggests that veterans would welcome such an option. It would represent a step beyond simply contracting for care and instead provide for coordination of health care benefits. The anticipated result would be that veterans who now often must choose between two or more health plans would get better, VA-coordinated, and less costly care.

VA's Deputy Under Secretary for Health cited the importance of developing mechanisms for coordinating benefits at the Subcommittee's May 17 hearing:

> Providing incentives in health care is a difficult proposition. Having said that, I think we can make significant progress in clarifying benefits for military veterans and retirees. Many are eligible for VA benefits and retiree benefits and many are eligible for Medicare, and there is a significant amount of shopping of benefits between the systems that results in wasting of resources and it results in poor coordination of care.

The reported bill offers a limited model for testing coordination of hospital benefits in a manner that promises to improve access and veteran satisfaction without diminishing the quality of patient care.

In providing for siting the program in up to four geographic areas, the intent is that such geographic areas would be relatively circumscribed and would not encompass the area of an entire "VISN" (one of the 22 veterans' integrated service networks). The Committee anticipates, for example, that the catchment area of the Brevard, FL outpatient clinic in east central Florida would be one of the areas designated for this program. The Committee intends further that VA, in considering potential areas for siting this program, avoid any situation where the establishment of such a program would have the likely effect of so diminishing the number of veterans receiving care at a VA medical center so as to reduce the patient base to the point at which that facility would have to consider eliminating services.

The Committee also seeks to avoid a situation in which either program costs markedly exceed initial projections or the impact on a VA medical center is more profound than anticipated, with the result that continued expansion of the program would likely impair the efficient operation of that facility. In addition, the program is specifically designed to address a coordinated benefit. This means that VA must pre-approve any care-intentionally limited to acute medical and general services-that program enrollees receive in community hospitals. This will allow VA to remain responsible for delivering the specialized care it delivers best, including its special emphasis programs, mental health programs, and inpatient long-term care services. In order to ensure that VA not erode its current services, the Committee has introduced a $50 million annual limitation on expenditures, including administrative expenses, that the program would allow. This limit does not apply to expenditures for emergency care which VA is now authorized to pay in limited circumstances under authority granted in Public Law 106–117. The Committee has also addressed concerns that the program serves

only "wealthier" veterans. This proposal strongly recommends that VA sites enroll up to 15 percent of its participants who lack any insurance. VA will sponsor the full costs of these individuals' care in the community.

The Committee envisions that VA will select sites that best meet the criteria outlined in the bill. Once sites are selected, VA directors should request proposals from providers within the designated project area and select providers based upon such factors as reimbursement rates, accreditation by appropriate agencies (such as the Joint Commission on Accreditation of Healthcare Organizations), other indicators of quality, the availability of services, and the provider's ability and willingness to ensure adequate exchange of patient information with VA to enhance veterans' continuity of care and provide for effective utilization review. VA may select as many local providers as meet these criteria to ensure adequate coverage for the pilot program area. In addition, the Committee intends that patients who volunteer to participate in this pilot program be limited to those who, in general, require short duration, general medical and surgical inpatient care as those terms are defined in title 38, United States Code. The Committee imposed this limitation out of concern that VA's specialized medical programs—unique national VA resources for the care of severely disabled veterans—not be eroded or otherwise affected negatively by this pilot program. To reiterate, it is the Committee's intent that this pilot program be directed to promote veterans' access to care and convenience in communities where a VA community based clinic operates distant from its host VA medical center, and in instances in which patients under its care need short periods of general hospital care that can be obtained from community hospitals.

COMPENSATED WORK THERAPY PROGRAM

The Compensated Work Therapy Program (CWT) is a therapeutic program authorized by section 1718 of title 38, United States Code, which VA employs in the rehabilitation of veteran-patients. Veterans are paid for work performed on contracts with governmental and industrial entities. This work-based model helps veterans re-enter the work force while enabling them to increase self confidence and improve their ability to adjust appropriately to the work setting. VA data indicate that some 85 percent admitted to the program have substance abuse problems; 66 percent are homeless; and 44 percent have been diagnosed with major mental health disorders. The program has enjoyed success in assisting these often-challenging patients in making the transition from medical settings into the community by developing the capacity for work and increasing their self-worth.

Nearly 15,000 veterans were treated in 101 different CWT programs throughout the country in fiscal year 1999. These veterans earned over $43.8 million for work performed on more than 3,600 contracts. The traditional CWT setting was in the nature of a sheltered workshop environment at the VA medical center. Work might range from simple collating tasks to fabrication of elaborate electromechanical subassemblies or machine shop operations using technologically sophisticated equipment. VA also employs a second model, in the nature of a "transitional work experience," in which

participants work at industry sites (including VA medical centers and other Federal agency settings). The latter mode, broadly supported in the field of rehabilitation, has proven effective in helping veterans transition to full employment. The rate of placement into employment from CWT is 43 percent, with another seven percent of participating veterans entering various training programs.

The Committee has become aware that as the "transitional work experience" component of the program has grown, more program participants are placed at risk of work-related injury for which they can receive no compensation. The risk of injury is real with transitional therapeutic work opportunities being provided at sites such as manufacturing settings and construction sites. In the event of work-related injury while participating in a CWT program, participants are not entitled to any worker compensation benefits. Veterans are not considered "employees" of either the United States, or of the private entity where they may work. Rather, their status is as patients, and the work they perform is undertaken in the context of medical rehabilitative treatment, prescribed by a VA physician and monitored by VA clinical staff.

In the past, CWT jobs have been relatively safe, with few adverse consequences, and the Committee understands that in instances when CWT participants have incurred injuries in the course of such participation, VA has typically awarded the veteran benefits under section 1151 of title 38, United States Code. In that instance, VA has considered a work-related injury as if it were service-incurred. With amendments to section 1151 in section 422 of Public Law 104–204 (adding a requirement that the injury or death have been due to negligence or fault, or have been unforeseeable), the VA Office of General Counsel has advised CWT program staff that in a routine case a veteran now has little actual recourse under section 1151. The situation raises concern about the viability of continuing the transitional work experience model. To ensure that these participants in the work therapy program are protected financially in the event of work-related injury, the reported bill would make them eligible for compensation benefits under section 1151 without regard to whether the injury was the result of negligence.

In proposing to provide CWT participants with such financial protection in the event of injury, the Committee is proposing the same remedy Congress employed three years ago in an analogous situation. In that instance, it provided such protection to participants in VA's vocational rehabilitation program. Under that program, as under the CWT program, participants work in community settings where they are at risk for injury. In 1996, Congress provided that veterans injured while working in the vocational rehabilitation program could receive compensation benefits under section 1151 without regard to whether the injury was the result of negligence. The reported bill would provide the same coverage to CWT program participants.

## OVERSIGHT FINDINGS

No oversight findings have been submitted to the committee by the Committee on Government Reform.

ADMINISTRATION VIEWS

At the Subcommittee on Health Hearing on VA Capital Asset Planning, April 5, 2000, Frances Murphy, M.D., Acting Deputy Under Secretary for Policy and Management, gave the following written testimony concerning changes in VA health care:

> VA was a hospital-based, disease-oriented, impersonal organization of medical centers. The "New VA" is an integrated health system that provides a continuum of accessible, coordinated, patient-centered care. We have seen demonstrable improvements in our capacity to achieve consistently reliable, accessible, satisfying, high-quality care. We continue to face challenges of reducing medical errors in our health care; of meeting the needs of an aging population; of incorporating the rapid growth of scientific knowledge into daily practice; of incorporating expensive new medical and information technologies; and of realigning our infrastructure to more effectively support current health care needs.
>
> * * * * *
>
> The transformation that is occurring in how health care is provided has outpaced our ability to make infrastructure changes. VA's infrastructure was built largely at a time when bed based care was the standard mode of providing health care. As described above, over the past 5 years VA has significantly shifted care from inpatient to ambulatory care delivery. We have also significantly moved care closer to the patient by establishing Community Based Clinics and home care. We currently face the challenge of realigning our infrastructure to optimally support how health care is being delivered today and will be delivered in the future.

At the April 12, 2000, Subcommittee on Health hearing on Status of Recruitment, Retention, and Compensation of the VA Health Care Work Force, Kenneth J. Clark, Chief Network Officer, VHA, submitted testimony on VA professional personnel to include the following:

> At the present time, health care staffing in the VA health care system is relatively stable and we are not currently experiencing any widespread or critical staffing shortage for our health care occupations.
>
> However, there are some specific problem areas—individual locations that are experiencing some difficulties for some occupations and non-VA pay trends for dentists and pharmacists are beginning to create difficulties.
>
> * * * * *
>
> We believe that the Department needs the flexibility to consider salary information beyond and in addition to the BLS results if we are to retain the ability to adjust pay rates when justified and necessary to maintain a competitive stance with the community, whether it be to set rates for remote locations, for specialized groups of nurses, or for pay comparability, should the BLS survey data not be ade-

quate to VA's staffing needs. Thus, VA favors retention of its current authority to conduct local surveys where BLS data are inadequate, not yet validated, for too large an area, or offer insufficient detail on specialties.

* * * * *

When the amounts of special pay for dentists were established in P.L. 102–40, the Department was not experiencing significant turnover or retention difficulties for dentists. For that reason, special pay increases at the level of those for physicians were not put in place.

Although VA does not currently have a widespread recruitment and retention problem for dentists, there are some areas where problems exist. Almost 70 percent of VA full-time dentists will be eligible for regular or early retirement in the next three years. Therefore, we are concerned that as VA dentists retire, it will be difficult to attract the best qualified dentists to work in the VA, given the gap that exists between VA and non-VA compensation packages. VA is currently reviewing legislative options that would mitigate these potential problems.

* * * * *

One occupation for which VA is currently experiencing increased recruitment and retention difficulties is pharmacist. Currently, VA pharmacists are not leaving their jobs to pursue private sector opportunities (most losses are due to retirements); rather VA is experiencing some increased difficulty recruiting new pharmacists.

There is a significant increase in the number of special salary rate authorizations for pharmacists. The Department is receiving requests for new or increased special rates on almost a daily basis. VA will continue to monitor the ceiling on special rates contained in 38 U.S.C. 7455(c) to ensure that restrictions in salary adjustments do not become problematic.

## CONGRESSIONAL BUDGET OFFICE COST ESTIMATE

At the time of filing this report, the Congressional Budget Office had not provided the Committee with a cost estimate.

## APPLICABILITY TO LEGISLATIVE BRANCH

The reported bill would not be applicable to the legislative branch under the Congressional Accountability Act, Public Law 104–1, because the bill would only affect certain Department of Veterans Affairs programs and benefits recipients.

## STATEMENT OF FEDERAL MANDATES

The reported bill would not establish a federal mandate under the Unfunded Mandates Reform Act, Public Law 104–4.

STATEMENT OF CONSTITUTIONAL AUTHORITY

Pursuant to Article I, section 8 of the United States Constitution, the reported bill is authorized by Congress' power to "provide for the common Defense and general Welfare of the United States."

CHANGES IN EXISTING LAW MADE BY THE BILL, AS REPORTED

In compliance with clause 3(e) of rule XIII of the Rules of the House of Representatives, changes in existing law made by the bill, as reported, are shown as follows (existing law proposed to be omitted is enclosed in black brackets, new matter is printed in italics, existing law in which no change is proposed is shown in roman):

## TITLE 38, UNITED STATES CODE

* * * * * * *

# PART II—GENERAL BENEFITS

* * * * * * *

SUBCHAPTER VI—GENERAL COMPENSATION PROVISIONS

### § 1151. Benefits for persons disabled by treatment or vocational rehabilitation

(a) Compensation under this chapter and dependency and indemnity compensation under chapter 13 of this title shall be awarded for a qualifying additional disability or a qualifying death of a veteran in the same manner as if such additional disability or death were service-connected. For purposes of this section, a disability or death is a qualifying additional disability or qualifying death if the disability or death was not the result of the veteran's willful misconduct and—

(1) * * *

(2) the disability or death was proximately caused *(A)* by the provision of training and rehabilitation services by the Secretary (including by a service-provider used by the Secretary for such purpose under section 3115 of this title) as part of an approved rehabilitation program under chapter 31 of this title, *or (B) by participation in a program (known as a "compensated work therapy program") under section 1718 of this title*.

* * * * * * *

## CHAPTER 17—HOSPITAL, NURSING HOME, DOMICILIARY, AND MEDICAL CARE

SUBCHAPTER I—GENERAL

Sec.
1701. Definitions.

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*1708. Temporary lodging.*

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### *§ 1708. Temporary lodging*

*(a) The Secretary may furnish persons described in subsection (b) with temporary lodging in a Fisher house or other appropriate facility in connection with the examination, treatment, or care of a veteran under this chapter or, as provided for under subsection (e)(5), in connection with benefits administered under this title.*

*(b) Person to whom the Secretary may provide lodging under subsection (a) are the following:*

*(1) A veteran who must travel a significant distance to receive care or services under this title.*

*(2) A member of the family of a veteran and others who accompany a veteran and provide the equivalent of familial support for such veteran.*

*(c) In this section, the term "Fisher house" means a housing facility that—*

*(1) is located at, or in proximity to, a Department medical facility;*

*(2) is available for residential use on a temporary basis by patients of that facility and others described in subsection (b)(2); and*

*(3) is constructed by, and donated to the Secretary by, the Zachary and Elizabeth M. Fisher Armed Services Foundation.*

*(d) The Secretary may establish charges for providing lodging under this section. The proceeds from such charges shall be credited to the medical care account and shall be available until expended for the purposes of providing such lodging.*

*(e) The Secretary shall prescribe regulations to carry out this section. Such regulations shall include provisions—*

*(1) limiting the duration of such lodging;*

*(2) establishing standards and criteria under which medical facilities may set charges for such lodging;*

*(3) establishing criteria for persons considered to be accompanying a veteran;*

*(4) establishing criteria for the use of such premises; and*

*(5) any other limitations, conditions, and priorities that the Secretary considers appropriate with respect to temporary lodging under this section.*

SUBCHAPTER II—HOSPITAL, NURSING HOME OR DOMICILIARY CARE AND MEDICAL TREATMENT

**§ 1710. Eligibility for hospital, nursing home, and domiciliary care**

(a)(1) * * *

* * * * * * *

(4) The requirement in paragraphs (1) and (2) that the Secretary furnish hospital care and medical services, and the [requirement in] *requirements in section 1710A(a) and* section 1710B of this title that the Secretary provide a program of extended care services, shall be effective in any fiscal year only to the extent and in the amount provided in advance in appropriations Acts for such purposes.

* * * * * * *

**§ 1710A. Required nursing home care**

(a) The Secretary *(subject to section 1710(a)(4) of this title)* shall provide nursing home care which the Secretary determines is needed (1) to any veteran in need of such care for a service-connected disability, and (2) to any veteran who is in need of such care and who has a service-connected disability rated at 70 percent or more.

* * * * * * *

SUBCHAPTER III—MISCELLANEOUS PROVISIONS RELATING TO HOSPITAL AND NURSING HOME CARE AND MEDICAL TREATMENT OF VETERANS

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***§ 1725A. Coordination of hospital benefits: pilot program***

*(a) The Secretary may carry out a pilot program in not more than four geographic areas of the United States to improve access to, and coordination of, inpatient care of eligible veterans. Under the pilot program, the Secretary, subject to subsection (b), may pay certain costs described in subsection (b) for which an eligible veteran would otherwise be personally liable. The authority to carry out the pilot program shall expire on September 30, 2005.*

*(b) In carrying out the program described in subsection (a), the Secretary may pay the costs authorized under this section for hospital care and medical services furnished on an inpatient basis in a non-Department hospital to an eligible veteran participating in the program. Such payment may cover the costs for applicable plan deductibles and coinsurance and the reasonable costs of such inpatient care and medical services not covered by any applicable health-care plan of the veteran, but only to the extent such care and services are of the kind authorized under this chapter. The Secretary shall limit the care and services for which payment may be made under the program to general medical and surgical services and shall require that such services may be provided only upon preauthorization by the Secretary.*

*(c)(1) A veteran described in paragraph (1) or (2) of section 1710(a) of this title is eligible to participate in the pilot program if the veteran—*

*(A) is enrolled to receive medical services from an outpatient clinic operated by the Secretary which is (i) within reasonable proximity to the principal residence of the veteran, and (ii) located within the geographic area in which the Secretary is carrying out the program described in subsection (a);*

*(B) has received care under this chapter within the 24-month period preceding the veteran's application for enrollment in the pilot program;*

*(C) as determined by the Secretary before the hospitalization of the veteran (i) requires such hospital care and services for a non-service-connected condition, and (ii) could not receive such services from a clinic operated by the Secretary; and*

*(D) elects to receive such care under a health-care plan (other than under this title) under which the veteran is entitled to receive such care.*

*(2) Nothing in this section shall be construed to reduce the authority of the Secretary to contract with non-Department facilities for care of a service-connected disability of a veteran.*

*(3) Notwithstanding subparagraph (D) of paragraph (1), the Secretary shall ensure that not less than 15 percent of the veterans participating in the program are veterans who do not have a health-care plan.*

*(d) As part of the program under this section, the Secretary shall, through provision of case-management, coordinate the care being furnished directly by the Secretary and care furnished under the program in non-Department hospitals to veterans participating in the program.*

*(e)(1) In designating geographic areas in which to establish the program under subsection (a), the Secretary shall ensure that—*

*(A) the areas designated are geographically dispersed;*

*(B) at least 70 percent of the veterans who reside in a designated area reside at least two hours driving distance from the closest medical center operated by the Secretary which provides medical and surgical hospital care; and*

*(C) the establishment of the program in any such area would not result in jeopardizing the critical mass of patients needed to maintain a Department medical center that serves that area.*

*(2) Notwithstanding paragraph (1)(B), the Secretary may designate for participation in the program at least one area which is in proximity to a Department medical center which, as a result of a change in mission of that center, does not provide hospital care.*

*(f)(1) Not later than September 30, 2002, the Secretary shall submit to the Committees on Veterans' Affairs of the Senate and House of Representatives a report on the experience in implementing the pilot program under subsection (a).*

*(2) Not later than September 30, 2004, the Secretary shall submit to those committees a report on the experience in operating the pilot program during the first two full fiscal years during which the pilot program is conducted. That report shall include—*

*(A) a comparison of the costs incurred by the Secretary under the program and the cost experience for the calendar year preceding establishment of the program at each site at which the program is operated;*

*(B) an assessment of the satisfaction of the participants in the program; and*

*(C) an analysis of the effect of the program on access and quality of care for veterans.*

*(g) The total amount expended for the pilot program in any fiscal year (including amounts for administrative costs) may not exceed $50,000,000.*

*(h) For purposes of this section, the term "health-care plan" has the meaning given that term in section 1725(f)(3) of this title.*

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# PART V—BOARDS, ADMINISTRATIONS, AND SERVICES

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## CHAPTER 73—VETERANS HEALTH ADMINISTRATION—ORGANIZATION AND FUNCTIONS

SUBCHAPTER I—ORGANIZATION



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### SUBCHAPTER I—ORGANIZATION

* * * * * * *

### § 7306. Office of the Under Secretary for Health

(a) * * *

* * * * * * *

(f) In organizing the Office and appointing persons to positions in the Office, the Under Secretary shall ensure that—

(1) the Office is staffed so as to provide the Under Secretary, through a designated clinician in the appropriate discipline in each instance, with expertise and direct policy guidance on—

(A) * * *

(B) the programs established under section 1712A of this title; **[**and**]**

(2) with respect to the programs established under section 1712A of this title, a clinician with appropriate expertise in those programs is responsible to the Under Secretary for the management of those programs**[**.**]***; and*

*(3) a physician assistant with appropriate experience (who may have a permanent duty station at a Department medical care facility in reasonable proximity to Washington, DC) advises the Under Secretary on all matters relating to the utiliza-*

*tion and employment of physician assistants in the Administration.*

* * * * * * *

SUBCHAPTER II—GENERAL AUTHORITY AND ADMINISTRATION

**§ 7321. Committee on Care of Severely Chronically Mentally Ill Veterans**

(a) * * *

* * * * * * *

(d)(1) * * *

(2) Not later than February 1, 1998, and February 1 of each of the [three] *six* following years, the Secretary shall submit to the Committees on Veterans' Affairs of the Senate and House of Representatives a report containing information updating the reports submitted under this subsection before the submission of such report.

* * * * * * *

***§ 7323. Required consultations with nurses***

*The Under Secretary for Health shall ensure that—*

*(1) the director of a geographic service area, in formulating policy relating to the provision of patient care, shall consult regularly with a senior nurse executive or senior nurse executives; and*

*(2) the director of a medical center shall, to the extent feasible, include a registered nurse as a member of any committee used at that medical center to provide recommendations or decisions on medical center operations or policy affecting clinical services, clinical outcomes, budget, or resources.*

* * * * * * *

SUBCHAPTER IV—RESEARCH CORPORATIONS

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**§ 7368. Expiration of authority**

No corporation may be established under this subchapter after December 31, [2000] *2005*.

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**CHAPTER 74—VETERANS HEALTH ADMINISTRATION—PERSONNEL**

* * * * * * *

SUBCHAPTER I—APPOINTMENTS

* * * * * * *

**§ 7402. Qualifications of appointees**

(a) * * *

(b)(1) * * *

* * * * * * *

(9) SOCIAL WORKER.—To be eligible to be appointed to a social worker position, [a person must hold a master's degree in social work from a college or university approved by the Secretary and satisfy the social worker licensure, certification, or registration requirements, if any, of the State in which the social worker is to be employed, except that the Secretary may waive the licensure, certification, or registration requirement of this paragraph for an individual social worker for a reasonable period, not to exceed 3 years, in order for the social worker to take any actions necessary to satisfy the licensure, certification, or registration requirements of such State.] *a person must—*

*(A) hold a master's degree in social work from a college or university approved by the Secretary; and*

*(B) be licensed or certified to independently practice social work in a State, except that the Secretary may waive the requirement of licensure or certification for an individual social worker for a reasonable period of time recommended by the Under Secretary for Health.*

* * * * * * *

**§ 7405. Temporary full-time appointments, part-time appointments, and without-compensation appointments**

(a) * * *

* * * * * * *

(c)(1) * * *

[(2) Temporary full-time appointments of persons who have successfully completed a full course of nursing in a recognized school of nursing, approved by the Secretary, or who have successfully completed a full course of training for any category of personnel described in paragraph (3) of section 7401 of this title in a recognized education or training institution approved by the Secretary, and who are pending registration or licensure in a State, or certification by a national board recognized by the Secretary, shall not exceed two years.]

*(2) A temporary full-time appointment may not be made for a period in excess of two years in the case of a person who—*

*(A) has successfully completed—*

*(i) a full course of nursing in a recognized school of nursing, approved by the Secretary; or*

*(ii) a full course of training for any category of personnel described in paragraph (3) of section 7401 of this title, or as a physician assistant, in a recognized education or training institution approved by the Secretary; and*

*(B) is pending registration or licensure in a State or certification by a national board recognized by the Secretary.*

*(3)(A) Temporary full-time appointments of persons in positions referred to in subsection (a)(1)(D) shall not exceed three years.*

*(B) Temporary full-time appointments under this paragraph may be renewed for one or more additional periods not in excess of three years each.*

[(3)] *(4)* Temporary full-time appointments of other personnel may not be for a period in excess of one year except as authorized in subsection (f).

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SUBCHAPTER III—SPECIAL PAY FOR PHYSICIANS AND DENTISTS

* * * * * * *

**§ 7435. Special pay: full-time dentists**

(a) * * *

(b) The special pay factors, and the annual rates, applicable to full-time dentists are as follows:

(1) For full-time status, [$3,500] *$9,000*.

(2)(A) For length of service as a dentist within the Veterans Health Administration—

| [Length of Service | Rate | |
|---|---|---|
| | Min-imum | Max-imum |
| 2 years but less than 4 years | $1,000 | $2,000 |
| 4 years but less than 8 years | 2,000 | 3,000 |
| 8 years but less than 12 years | 3,000 | 3,500 |
| 12 years or more | 3,000 | 4,000] |

| *Length of Service* | *Rate* | |
|---|---|---|
| | *Minimum* | *Maximum* |
| *1 year but less than 2 years* | *$1,000* | *$2,000* |
| *2 years but less than 4 years* | *4,000* | *5,000* |
| *4 years but less than 8 years* | *5,000* | *8,000* |
| *8 years but less than 12 years* | *8,000* | *12,000* |
| *12 years but less than 20 years* | *12,000* | *15,000* |
| *20 years or more* | *15,000* | *18,000.* |

(3)(A) For service in a dental specialty with respect to which there are extraordinary difficulties (on a nationwide basis or on the basis of the needs of a specific medical facility) in the recruitment or retention of qualified dentists, an annual rate of not more than [$20,000] *$30,000*.

* * * * * * *

(4)(A) For service in any of the following executive positions, an annual rate not to exceed the rate applicable to that position as follows:

| [Position | Rate | |
|---|---|---|
| | Min-imum | Max-imum |
| Service Director | $1,000 | $9,000 |
| Deputy Service Director | 1,000 | 8,000 |
| Chief of Staff or in an Executive Grade | 1,000 | 8,000 |
| Director Grade | 0 | 8,000 |

| [Position | Rate | |
|---|---|---|
| | Min-imum | Max-imum |
| Service Chief (or in a comparable position as determined by the Secretary) | 1,000 | 5,000] |

| *Position* | *Rate* | |
|---|---|---|
| | *Minimum* | *Maximum* |
| *Chief of Staff or in an Executive Grade* | *$14,500* | *$25,000* |
| *Director Grade* | *0* | *25,000* |
| *Service Chief (or in a comparable position as determined by the Secretary)* | *4,500* | *15,000.* |

(B) For service in any of the following executive positions, the annual rate applicable to that position as follows:

| [Position | Rate |
|---|---|
| Assistant Under Secretary for Health (or in a comparable position as determined by the Secretary) | $10,000 |
| Deputy Assistant Under Secretary for Health | 10,000] |

| *Position* | *Rate* |
|---|---|
| *Deputy Service Director* | *$20,000* |
| *Service Director* | *25,000* |
| *Deputy Assistant Under Secretary for Health* | *27,500* |
| *Assistant Under Secretary for Health (or in a comparable position as determined by the Secretary)* | *30,000.* |

* * * * * * *

(6) For service in a specific geographic location with respect to which there are extraordinary difficulties in the recruitment or retention of qualified dentists in a specific category of dentists, an annual rate not more than [$5,000] *$12,000*.

* * * * * * *

*(8) For a dentist who has successfully completed a post-graduate year of hospital-based training in a program accredited by the American Dental Association, an annual rate of $2,000 for each of the first two years of service after successful completion of that training.*

### § 7438. Special pay: coordination with other benefits laws

(a) * * *
(b)(1) * * *

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*(5) Notwithstanding paragraphs (1) and (2), a dentist employed as a dentist in the Veterans Health Administration on the effective date of section 102 of the Department of Veterans Affairs Health Care Personnel Act of 2000 shall be entitled to have special pay paid to the dentist under section 7435(b)(2)(A) of this title (referred to as "tenure pay") considered basic pay for the purposes of chapter 83 or 84, as appropriate, of title 5 only as follows:*

*(A) In an amount equal to the amount that would have been so considered under such section on the day before such effective*

*date based on the rates of special pay the dentist was entitled to receive under that section on the day before such effective date.*

*(B) With respect to any amount of special pay received under that section in excess of the amount such dentist was entitled to receive under such section on the day before such effective date, in an amount equal to 25 percent of such excess amount for each two years that the physician or dentist has completed as a physician or dentist in the Veterans Health Administration after such effective date.*

[(5)] *(6)* For purposes of this subsection:

(A) * * *

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SUBCHAPTER IV—PAY FOR NURSES AND OTHER HEALTH–CARE PERSONNEL

**§ 7451. Nurses and other health-care personnel: competitive pay**

(a) * * *

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(d)(1) [The rates] *Subject to subsection (e), the rates* of basic pay for each grade in a covered position shall be adjusted periodically in accordance with this subsection in order to achieve the purposes of this section. Such adjustments shall be made—

(A) whenever there is an adjustment under section 5305 of title 5 in the rates of pay under the General Schedule, with the adjustment under this subsection to have the same effective date *and to be by the same percentage* as the adjustment in the rates of basic pay under the General Schedule; and

(2) An adjustment in rates of basic pay under this subsection for a grade shall be carried out by adjusting the amount of minimum rate of basic pay for that grade in accordance with paragraph (3) and then adjusting the other rates for that grade to conform to the requirements of subsection (c). [Such] *Except as provided in paragraph (1)(A), such* an adjustment in the minimum rate of basic pay for a grade shall be made by the director of a Department health-care facility so as to achieve consistency with the beginning rate of compensation for corresponding health-care professionals in the Bureau of Labor Statistics (BLS) labor-market area of that facility.

(3)(A) * * *

(B) In the case of a Department health-care facility located in an area for which the Bureau of Labor Statistic does not have current information on beginning rates of compensation for corresponding health-care professional for the labor-market area of that facility for any covered position, the director of that facility shall conduct a survey in accordance with this subparagraph and shall adjust the amount of the minimum rate of basic pay for grades in that covered position at that facility based upon that survey. *To the extent practicable, the director shall use third-party industry wage surveys to meet the requirements of the preceding sentence.* Any such survey shall be conducted in accordance with regulations prescribed by the Secretary. Those regulations shall be developed in consultation with the Secretary of Labor in order to ensure that the director of

a facility collects information that is valid and reliable and is consistent with standards of the Bureau. The survey should be conducted using methodology comparable to that used by the Bureau in making industry-wage surveys except to the extent determined infeasible by the Secretary. *To the extent practicable, all surveys conducted pursuant to this subparagraph or subparagraph (A) shall include the collection of salary midpoints, actual salaries, lowest and highest salaries, average salaries, bonuses, incentive pays, differential pays, actual beginning rates of pay and such other information needed to meet the purpose of this section.* Upon conducting a survey under this subparagraph the director concerned shall determine, not later than 30 days after the date on which the collection of information through the survey is completed *or published*, whether an adjustment in rates of pay for employees at that facility for any covered position is necessary in order to meet the purposes of this section. If the director determines that such an adjustment is necessary, the adjustment, based upon the information determined in the survey, shall take effect on the first day of the first pay period beginning after that determination.

(C)(i) * * *

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**[**(iii) The authority of the director to use such additional data under this subparagraph with respect to certified registered nurse anesthetists expires on January 1, 1998.**]**

* * * * * * *

**[**(e) Adjustments in rates of basic pay under subsection (d) may increase or reduce the rates of basic pay applicable to any grade of a covered position. In the case of such an adjustment that reduces the rates of pay for a grade, an employee serving at a Department health-care facility on the day before the effective date of that adjustment in a position affected by the adjustment may not (by reason of that adjustment) incur a reduction in the rate of basic pay applicable to that employee so long as the employee continues to serve in that covered position at that facility. If such an employee is subsequently promoted to a higher grade, or advanced to a higher step within the employee's grade, for which the rate of pay as so adjusted is lower than the employee's rate of basic pay on the day before the effective date of the promotion, the employee shall continue to be paid at a rate of basic pay not less than the rate of basic pay applicable to the employee before the promotion so long as the employee continues to serve in that covered position at that facility.**]**

*(e)(1) An adjustment in a rate of basic pay under subsection (d) may not reduce the rate of basic pay applicable to any grade of a covered position.*

*(2) The director of a Department health-care facility, in determining whether to carry out a wage survey under subsection (d)(3) with respect to rates of basic pay for a grade of a covered position, may not consider as a factor in such determination the absence of a current recruitment or retention problem for personnel in that grade of that position. The director shall make such a determination based upon whether, in accordance with criteria established by the Secretary, there is a significant pay-related staffing problem at that facility in any grade for a position. If the director determines*

*that there is such a problem, or that such a problem is likely to exist in the near future, the Director shall provide for a wage survey in accordance with paragraph (3) of subsection (d).*

*(3) The Under Secretary for Health may, to the extent necessary to carry out the purposes of subsection (d), modify any determination made by the director of a Department health-care facility with respect to adjusting the rates of basic pay applicable to covered positions. Upon such action by the Under Secretary, any adjustment shall take effect on the first day of the first pay period beginning after such action. The Secretary shall ensure that the Under Secretary establishes a mechanism for the exercise of the authority in the preceding sentence.*

*(4) Each director of a Department health-care facility shall provide to the Secretary, not later than July 31 each year, a report on staffing for covered positions at that facility. The report shall include the following:*

*(A) Information on turnover rates and vacancy rates for each grade in a covered position, including a comparison of those rates with the rates for the preceding three years.*

*(B) The director's findings concerning the review and evaluation of the facility's staffing situation, including whether there is, or is likely to be, in accordance with criteria established by the Secretary, a significant pay-related staffing problem at that facility for any grade of a covered position and, if so, whether a wage survey was conducted, or will be conducted with respect to that grade.*

*(C) In any case in which the director conducts such a wage survey during the period covered by the report, information describing the survey and any actions taken or not taken based on the survey, and the reasons for taking (or not taking) such actions.*

*(D) In any case in which the director, after finding that there is, or is likely to be, in accordance with criteria established by the Secretary, a significant pay-related staffing problem at that facility for any grade of a covered position, determines not to conduct a wage survey with respect to that position, a statement of the reasons why the director did not conduct such a survey.*

*(5) Not later than September 30 of each year, the Secretary shall submit to the Committees on Veterans' Affairs of the Senate and House of Representatives a report on staffing for covered positions at Department healthcare facilities. Each such report shall include the following:*

*(A) A summary and analysis of the information contained in the most recent reports submitted by facility directors under paragraph (4).*

*(B) The information for each such facility specified in paragraph (4).*

(f) Not later than ⟦February 1 of 1991, 1992, and 1993⟧ *March 1 of each year*, the Secretary shall submit to the Committees on Veterans' Affairs of the Senate and House of Representatives a report regarding any pay adjustments under the authority of subsection ⟦(d)(1)(A)⟧ *(d)* effective during the 12 months preceding the submission of the report. Each such report shall set forth, by health-care facility, the percentage of such increases and, in any

case in which no increase was made, the basis for not providing an increase.

[(g) Not later than December 1 of 1991, 1992, and 1993, the Secretary shall submit to the Committees on Veterans' Affairs of the Senate and House of Representatives a report regarding the exercise of the authorities provided in this section for the preceding fiscal year. Each such report shall include the following:

[(1) A review of the use of the authorities provided in this section (including the Secretary's and Under Secretary for Health's actions, findings, recommendations, and other activities under this section) during the preceding fiscal year, including an assessment of the effects of the exercise of such authorities on the ability of the Department to recruit and retain qualified health-care professionals for covered positions.

[(2) The plans for the use of the authorities provided in this subchapter for the next fiscal year.

[(3) A description of the rates of basic pay in effect during the preceding fiscal year, with a comparison to the rates in effect during the previous fiscal year, shown by facility and by covered position.

[(4) The numbers of employees in covered positions (shown separately for registered nurses and for each other covered positions who during the preceding fiscal year (A) left employment with the Department, (B) left employment at one Department medical facility for employment at another Department medical facility, or (C) changed from full-time status to part-time status (and from part-time status to full-time status), and a summary of the reasons therefor.

[(5) The number of vacancies in covered positions in the Administration and a summary of the reasons that those positions are vacant.

[(6) The number of employees who during the preceding fiscal year left employment at a health-care facility in one Bureau of Labor Statistics labor-market area for employment at a health-care facility in another such labor-market area, without changing residence.

[(7) Justification for setting the maximum rate of basic pay for any grade at a rate in excess of 133 percent of the minimum rate of basic pay for that grade.

[(8) The discussion required by section 7452(b)(2) of this title.

[(9) The justification required by section 7452(e) of this title.

[(10) The number of nurses, shown by facility and by grade, who are on pay retention or in the top step of any grade and, with respect to those employees, comprehensive information (by facility) as to whether an extension of the pay grades was sought for these positions, and with respect to each such request for extension, whether such request was granted or denied.]

[(h)] *(g)* For the purposes of this section, the term "health-care facility" means a medical center, an independent outpatient clinic, or an independent domiciliary facility.

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**§ 7455. Increases in rates of basic pay**

(a) * * *

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(c)(1) The amount of any increase under subsection (a) in the maximum rate for any grade may not (except in the case of nurse anesthetists*, pharmacists,* and licensed physical therapists) exceed by two times the amount by which the maximum for such grade (under applicable provisions of law other than this subsection) exceeds the minimum for such grade (under applicable provisions of law other than this subsection), and the maximum rate as so increased may not exceed the rate paid for individuals serving as Assistant Under Secretary for Health.

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# PART VI—ACQUISITION AND DISPOSITION OF PROPERTY

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## CHAPTER 81—ACQUISITION AND OPERATION OF HOSPITAL AND DOMICILIARY FACILITIES; PROCUREMENT AND SUPPLY; ENHANCED–USE LEASES OF REAL PROPERTY

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SUBCHAPTER III—STATE HOME FACILITIES FOR FURNISHING DOMICILIARY, NURSING HOME, AND HOSPITAL CARE

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**§ 8136. Recapture provisions**

*(a)* If, within the 20-year period beginning on the date of the approval by the Secretary of the final architectural and engineering inspection of any project with respect to which a grant has been made under this subchapter (except that the Secretary, pursuant to regulations which the Secretary shall prescribe, may at the time of such grant provide for a shorter period than 20, but not less than seven years, based on the magnitude of the project and the grant amount involved, in the case of the acquisition, expansion, remodeling, or alteration of existing facilities), the facilities covered by the project cease to be operated by a State, a State home, or an agency or instrumentality of a State principally for furnishing domiciliary, nursing home, or hospital care to veterans, the United States shall be entitled to recover from the State which was the recipient of the grant under this subchapter, or from the then owner of such facilities, 65 percent of the then value of such project (but in no event an amount greater than the amount of assistance provided under this subchapter), as determined by agreement of the parties or by action brought in the district court of the United States for the district in which such facilities are situated.

*(b) The establishment and operation by the Secretary of an outpatient clinic in facilities described in subsection (a) shall not con-*

*stitute grounds entitling the United States to any recovery under that subsection.*

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SUBCHAPTER V—ENHANCED–USE LEASES OF REAL PROPERTY

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**§ 8163. Designation of property to be leased**

(a) * * *

* * * * * * *

(c)(1) * * *

**[**(2) The Secretary may not enter into an enhanced-use lease until the end of a 60-day period of continuous session of Congress following the date of the submission of notice under paragraph (1). For purposes of the preceding sentence, continuity of a session of Congress is broken only by an adjournment sine die, and there shall be excluded from the computation of such 60-day period any day during which either House of Congress is not in session during an adjournment of more than three days to a day certain.**]**

*(2) The Secretary may not enter into an enhanced use lease until the end of the 90-day period beginning on the date of the submission of notice under paragraph (1).*

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**DEPARTMENT OF VETERANS AFFAIRS EMPLOYMENT REDUCTION ASSISTANCE ACT OF 1999**

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# TITLE XI—VOLUNTARY SEPARATION INCENTIVE PROGRAM

**SEC. 1101. SHORT TITLE.**

This title may be cited as the "Department of Veterans Affairs Employment Reduction Assistance Act of 1999".

**SEC. 1102. PLAN FOR PAYMENT OF VOLUNTARY SEPARATION INCENTIVE PAYMENTS.**

(a) * * *

* * * * * * *

**[**(c) LIMITATION ON ELEMENTS AND PERSONNEL.—The plan under subsection (a) shall be limited to the elements of the Department, and the number of positions within such elements, as follows:

**[**(1) The Veterans Health Administration, 4,400 positions.

**[**(2) The Veterans Benefits Administration, 240 positions.

**[**(3) Department of Veterans Affairs Staff Offices, 45 positions.

**[**(4) The National Cemetery Administration, 15 positions.**]**

*(c) LIMITATION.—The plan under subsection (a) shall be limited to 8,110 positions within the Department.*

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**SEC. 1105. ADDITIONAL AGENCY CONTRIBUTIONS TO CIVIL SERVICE RETIREMENT AND DISABILITY FUND.**

(a) REQUIREMENT.—In addition to any other payments which it is required to make under subchapter III of chapter 83 or chapter 84 of title 5, United States Code, the Secretary shall remit to the Office of Personnel Management for deposit in the Treasury of the United States to the credit of the Civil Service Retirement and Disability Fund an amount equal to **[**26**]** *15* percent of the final basic pay of each employee of the Department who is covered under subchapter III of chapter 83 or chapter 84 of title 5, United States Code, to whom a voluntary separation incentive is paid under this title.

* * * * * * *

**SEC. 1109. LIMITATION; SAVINGS CLAUSE.**

(a) LIMITATION.—No voluntary separation incentive payment may be paid under this title based on the separation of an employee after December 31, **[**2000**]** *2002*.

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## SECTION 2 OF THE ACT OF JUNE 6, 1953

AN ACT Authorizing the transfer of certain property to the Veterans' Administration (in Johnson City, Tennessee) to the State of Tennessee.

**[**SEC. 2. Such conveyance shall contain a provision that said property shall be used primarily for training of the National Guard and for other military purposes, and that if the State of Tennessee shall cease to use the property so conveyed for the purposes intended, then title thereto shall immediately revert to the United States, and in addition, all improvements made by the State of Tennessee during its occupancy shall vest in the United States without payment of compensation therefor.**]**

○